

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05844  
24

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park, P.O. Glen Burnie</u> , 30 minutes		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marley Creek, Community Beach</u>	
3. NAME OF DECEASED (Type or print) <u>Georges Albert Arnold Jr.</u>		First <u>G</u>	Middle <u>A</u>
		Last <u>R</u>	4. DATE OF DEATH Month <u>June</u> Day <u>16th</u> Year <u>1957</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Georges Albert Arnold, Sr. (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Juanita P. Hossey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. G.A. Arnold, (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Drowning</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Marley Creek</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1.30</u> o. m. p. m. <u>6/16/57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marley Creek</u> 20f. (City or town) (County) (State) <u>Marley Park, A.A. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>6/16/57</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/20/57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Bethel Nat'l Cem.</u> 22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.L. Singletary</u>		ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR <u>JUN 20 1957</u> 24b. REGISTRAR'S SIGNATURE <u>L.J. Dallas</u>

WATERBURY STATE EXAMINER - MINING & METALLURGICAL EXAMINER

BUREAU V.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5882

## CERTIFICATE OF DEATH

Reg. Dist. No.

05845  
05845

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>38 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		d. STREET ADDRESS <b>None given</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Lester</b>	Middle <b>Aydelotte</b>	Last <b></b>	4. DATE OF DEATH <b>6 3 1957</b>	Month <b>6</b>	Day <b>3</b>	Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not given</b>	9. AGE (In years lost birthday) <b>51 yrs.</b>	IF UNDER 1 YEAR <b>51 yrs.</b>	IF UNDER 24 HRS. Months <b>—</b>	Days <b>—</b>	Hours <b>—</b>	Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not given</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Not given</b>		14. MOTHER'S MAIDEN NAME <b>Not given</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Coma</b> <i>260X</i>						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <b>Diabetes Mellitus</b>							
DUE TO <b>Diabetes Mellitus</b>									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	Day <b>19</b>	Year <b>57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Crownsville, Md.</b>	(County) <b></b>	(State) <b></b>	
21. I certify that I attended the deceased from <b>4/26</b> , 19 <b>57</b> to <b>6/3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/3</b> , 19 <b>57</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>			
ACTUAL SIGNATURE <i>Ludwig Benedict</i>			M.D.		DATE SIGNED <b>6/3/57</b>				
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/7/57</b>	22b. DATE THEREOF <b>6/7/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Halls Hill Cemetery Pocomoke City Md.</b>	22d. LOCATION (City, town, or county) <b>Pocomoke City Md.</b>	(State) <b></b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Robert</i>		ADDRESS <b>Chesapeake</b>	24a. REC'D BY REGISTRAR <b>6/7/57</b>	24b. REGISTRAR'S SIGNATURE <b>Dore E. White</b>					
			DATE <b>6/7/57</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
JUN 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5845

## CERTIFICATE OF DEATH

05846

21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Anne Arundel</i> <i>MARYLAND</i>		a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General Hosp.</i>		d. STREET ADDRESS <i>Legume Ct.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Robert Samuel Ball</i>		First <i>Robert</i>	Middle <i>Samuel</i>
Last <i>Ball</i>		DATE OF DEATH Month <i>6</i>	Day Year <i>13 1957</i>
6. SEX <i>Male</i>	6. COLOR OF RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-28-1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private family</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert S. Ball Sr.</i>		14. MOTHER'S M AIDEN NAME <i>Mary Simpkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-18-1751</i>	
17. INFORMANT <i>Maggie Slagle - Annapolis, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<i>Ch. Interstitial Nephritis</i> <i>yes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>289 Ac. &amp; Chronic Laryngitis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>130A</i>	
20c. TIME OF INJURY Hour a. p.m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 9, 1957</i> to <i>June 13, 1957</i> that I last saw the deceased alive on <i>June 12, 1957</i> , and that death occurred at <i>130A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Maurice F. Rawans M.D.</i>		ADDRESS (Street, city or town, state) <i>31 Southgate Ln</i>	
PHYSICIAN'S NAME (Type) <i>MAURICE F. RAWANS, MD</i>		DATE SIGNED <i>6/16/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-17-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) <i>Annapolis MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Geese Jr.</i>		ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 20 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Wm. J. Lynch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE BOARD OF HEALTH - SANITATION

CERTIFICATE OF DEATH

BUREAU V.  
RECEIVED  
JUN 21 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05847

21

## CERTIFICATE OF DEATH

Reg. Dist. No.

5846

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Walter</b>	Middle <b>Ernest</b>	Last <b>Barkes</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>23</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>March 25, 1894</b>
8. AGE (In years lost, birthday) <b>63</b>	9. IF UNDER 1 YEAR Months <b>63</b>	10. IF UNDER 24 HRS. Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>General Bldg.</b>	11. BIRTHPLACE (State or foreign country) <b>Fairfax, Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Barkes</b>		14. MOTHER'S MAIDEN NAME <b>Annie Higham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 57840-694</b>	
17. INFORMANT <b>Mrs Annie E. Smith- Sister- Same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO 002X (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/18</b> , 1957, to <b>6/23</b> , 1957, that I last saw the deceased alive on <b>6/23</b> , 1957, and that death occurred at <b>150</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John L. Hedeman, M.D.</i> ADDRESS (Street, city or town, state) <b>68 Franklin St.</b> DATE SIGNED <b>6/24/57</b> PHYSICIAN'S NAME (Type) <b>John Hedeman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 26, 57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Annapolis National Cemt.</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>6/26/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. J. French</b>	

DEPARTMENT OF HEALTH - SEATTLE - WASHINGTON STATE INSURANCE DEPARTMENT

CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. 2  
JUN 26 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5883

## CERTIFICATE OF DEATH

07/01/10  
22

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laurel, Md.</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>117 - 11th St. NE, Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel, Md.</b>		d. STREET ADDRESS <b>District Training School, Children's Center, 117 - 11th St., NE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Leslie</b>	Middle <b>Ann</b>	lost <b>Bayha</b>	4. DATE OF DEATH <b>June 27</b>	Month Day Year <b>June 27 1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12/9/46</b>	9. AGE (In years lost birthday) <b>10 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Robert E. Bayha</b>		14. MOTHER'S MAIDEN NAME <b>Ida Johnson Bayha</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. - - -		17. INFORMANT <b>District Training School, Children's Center, Laurel, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxiation</b> DUE TO 351X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>aspiration</b> DUE TO (c) <b>cerebral palsy</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>325.5 mental deficiency</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>mental deficiency</b>			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Anne Arundel, Md.</b>	(County) <b>Arling Co.</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>August</b> , 1956, to <b>June 27</b> , 1957, that I last saw the deceased alive on <b>June 26</b> , 1957, and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>Wilfred R. Ehrmantraut, M.D.</b>					
DATE SIGNED					
ACTUAL SIGNATURE <b>Wilfred R. Ehrmantraut, M.D.</b>					
PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-28-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dist. Tr. School</b>	22d. LOCATION (City, town, or county) <b>Anne Arundel, Md.</b>	(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Moore Jr. to Tr. School</b>			24a. REC'D BY REGISTRAR <b>Lorraine Hasley</b>	24b. REGISTRAR'S SIGNATURE <b>Lorraine Hasley</b>	
ADDRESS <b>John Moore Jr. to Tr. School</b>			DATE <b>6-27-57</b>		

## CERTIFICATE OF DEATH

MARSHALIA

NO DEATH  
REGISTRATION

BUREAU X

JUL 25 1957

RECEIVED

FBI - BIRMINGHAM

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05848

5884

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. George G. Meade		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x o Millersville.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS RFD #1 Box 59B			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH Month June Day 28 Year 57		
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 June 57	9. AGE (In years lost birthday) yrs. 3	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		
					12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Black				14. MOTHER'S MAIDEN NAME Audrey Joyce Strickland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> Heart failure INTERVAL BETWEEN ONSET AND DEATH 753.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Major central nervous congenital anomalies</i> (c) <i>Major Central nervous system congenital anomalies</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. s. p. m.	Month Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 0300 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED ACTUAL SIGNATURE <i>George Norman Schultz</i> M.D. 28 June 57							
PHYSICIAN'S NAME (Type) GEORGE NORMAN SCHULTZ, MD		U.S. Army Hospital, Ft Meade, Md					
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-2-57	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore, National	22d. LOCATION (City, town, or county) Baltimore, Md (State)				
23. FUNERAL DIRECTOR'S SIGNATURE W. M. COOK, (Wm. Cook, Inc., 1217 St. Paul Street)				24a. REC'D BY REGISTRAR DATE 28 June 57	24b. REGISTRAR'S SIGNATURE J. L. Saylor, 1/Lt MSC		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.

JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5885

05849

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Anne Arundel / MARYLAND		a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNNSVILLE		c. LENGTH OF STAY IN 1b 1 year 3 months BALTIMORE 3801.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) CROWNNSVILLE STATE HOSPITAL		d. STREET ADDRESS 216 N. Wolfe St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Ida	Middle G
Last CAMPER		4. DATE OF DEATH Month 6 Day 7 Year 1957	
5. SEX Female		6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-8-1880		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT GIVEN		10b. KIND OF BUSINESS OR INDUSTRY NOT GIVEN	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? MS			
13. FATHER'S NAME GEORGE CORMISH		14. MOTHER'S MAIDEN NAME MARIA CURNISH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) UNK		16. SOCIAL SECURITY NO. UNK	17. INFORMANT Hospital Records
Address CROWNNSVILLE STATE Hospital CROWNNSVILLE Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
023x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Congestive Heart Failure	
(b)		ARTERIOSCLEROTIC AND Syphilitic	
(c)		CARDIOVASCULAR DISEASE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
422.1		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-14, 1956, to 6-7, 1957, that I last saw the deceased alive on 6-7, 1957, and that death occurred at 11:15 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) CROWNNSVILLE, MD	
ACTUAL SIGNATURE Ludwig BENEDICT, M.D.		DATE SIGNED 6/8/57	
PHYSICIAN'S NAME (Type) Ludwig BENEDICT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Church Creek Cemetery
22d. LOCATION (City, town, or county) Cambridge, Dorchester Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Evelyn C. Gibson		24a. REC'D BY REGISTRAR DATE 6/11/57	24b. REGISTRAR'S SIGNATURE Z. M. Joyce
ADDRESS 6000 Grand Bay Ave			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5886

## CERTIFICATE OF DEATH

05850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>/</i>		d. STREET ADDRESS <i>/</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Carrington</i>		First	Middle
4. DATE OF DEATH <i>6 9 1957</i>		Last	Month
5. SEX <i>Male</i>		6. COLOR OR FACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>5-14-1888</i>		9. AGE (In years last birthday) yrs. <i>69</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hard Carrier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-05-2105</i>	
17. INFORMANT <i>James Logan</i>		Address <i>1211 N. St. Sicker St. Baltimore</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>162X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Baltimore</i>	
21. I certify that I attended the deceased from <i>5/12</i> , 1957, to <i>5/9</i> , 1957, that I last saw the deceased alive on <i>6/9</i> , 1957, and that death occurred at <i>1012</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson, M.D.</i>		ADDRESS (Street, city or town, state) <i>37 Leabell St. Annapolis 6/12/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. THEODORE H. JOHNSON</i>		DATE SIGNED <i>6/12/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-16-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Auburn</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Anna, M.D.</i>		ADDRESS <i>JUN 13 1957</i>	
24a. REC'D BY REGISTRAR <i>L. M. Jones</i>		24b. REGISTRAR'S SIGNATURE <i>L. M. Jones</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HIGHWAYS - SURVEYOR'S

CERTIFICATE OF DESIGN

BUREAU V. S.

JUN 13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

5887

## CERTIFICATE OF DEATH

Reg. Dist. No.

05851

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>lyr. 6 mos. 17 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> d. STREET ADDRESS <b>214 Center Street</b>		
3. NAME OF DECEASED (Type or print)	First <b>Emma</b>	Middle <b></b>	Last <b>Carter</b>	
4. DATE OF DEATH	Month <b>6</b>	Day <b>24</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1899</b>	
9. AGE (In years lost birthday) <b>57 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. KIND OF BUSINESS OR INDUSTRY <b>---</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Coats</b>	14. MOTHER'S MAIDEN NAME <b>Lydia Coats</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		
16. SOCIAL SECURITY NO. <b>Unk.</b>			17. INFORMANT <b>Hospital Records</b>	Address <b>Crownsville State Hospital Crownsville, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia and Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Hypertensive cardiovascular-renal disease</b> DUE TO of arteriosclerotic origin (c)				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Decubitus Ulcers</b> <b>715X</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/31</b> , 1957, to <b>6/24</b> , 1957, that I last saw the deceased alive on <b>6/24</b> , 1957, and that death occurred at <b>10:30A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Lionel McHenry Mapp.</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/28/57</b>		22b. DATE THEREOF <b>6/28/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS <b>822 Malvern Rd.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 25 1957</b>	24b. REGISTRAR'S SIGNATURE <b>J. M. Gaynor</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

WISCONSIN STATE DEPARTMENT OF HEALTH - STATISTICS

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 25 1957

REGISTRY

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5888

## CERTIFICATE OF DEATH

05852

25

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>A.A.C.O.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>50</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>15228 Sixth St.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5228 Sixth St.</i>				d. STREET ADDRESS <i>15228 Sixth St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Annes</i>		First	Middle	Last	4. DATE OF DEATH <i>June 19</i>	Month	Day	Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 27, 1882</i>		9. AGE (In years last birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR Months <i>7</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>		12. CITIZEN OF WHAT COUNTRY? <i>✓</i>			
13. FATHER'S NAME <i>Frank Melichar</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Lillian Brozik 5228 Sixth St.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eugene Schnitzer</i> M.D. ADDRESS (Street, city or town, state) <i>3904 S. Hanover St. Baltimore, Md.</i> DATE SIGNED <i>June 19, 1957</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 22, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Anne Arundel Co., Md.</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Bone</i>		ADDRESS <i>4001 Ritchie Hwy.</i>		24a. READ BY REGISTRAR <i>June 20, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Ma. Wilson</i>			
VS A15 (4) 15M 9/55									

## CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
JUN 21 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5889

## CERTIFICATE OF DEATH

05853

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Levins</i>	c. LENGTH OF STAY IN 1b <i>25 days</i>	b. COUNTY <i>Anne Arundel</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Camp</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	d. STREET ADDRESS <i></i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Clarence Charles Chegwin</i>		First <i>C</i>	Middle <i>C</i>	Last <i>C</i>	4. DATE OF DEATH <i>June 18 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>March 25 1927</i>	9. AGE (In years (last birthday) <i>30 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>filling station</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James W. Chegwin</i>		14. MOTHER'S MAIDEN NAME <i>Ergalla Perry</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-22-4457</i>		17. INFORMANT <i>Mrs Clarence C. Chegwin</i>	Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>430.0</i>		DUE TO <i>acute myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		(b) <i>cardiac arrhythmia and</i>				
DUE TO <i>Septicemia</i>		(c) <i></i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i></i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert C. Henry M.D.</i>		ADDRESS (Street, city or town, state) <i></i> DATE SIGNED <i></i>				
PHYSICIAN'S NAME (Type) <i>ROBERT C. HENRY</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/20/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Meadowridge Mem Park</i>	22d. LOCATION (City, town, or county) <i>Hanover Md</i>	(State) <i></i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Danaher</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>JUN 21 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Clare Haskins</i>		

MANHATTAN STATE DEPARTMENT OF HEALTH - CALIFORNIA 18

CERTIFICATE OF DEATH

BUREAU V. S.  
REGEIVED  
JUN 24 1957

19<sup>th</sup>  
tems 20 Film 217 7-5-57 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05854

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.D.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>1wk</i>	b. COUNTY <i>A.A.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tracy's</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.D. General</i>		d. STREET ADDRESS <i>1</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>AMANDA</i>	Middle <i>CHEW</i>	Last <i>16</i>			
4. DATE OF DEATH <i>6</i>	Month <i>16</i>	Day <i>1957</i>	Year			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 15 1905</i>			
9. AGE (In years last birthday) <i>52</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>COOK</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	12. BIRTHPLACE (State or foreign country) <i>Nutwell Md.</i>			
13. FATHER'S NAME <i>FRANK QUILL</i>	14. MOTHER'S MAIDEN NAME <i>ELLA PRATT</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213285397</i>	17. INFORMANT <i>Luther Chew Tracy's Md.</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>931.8</i>		INTERVAL BETWEEN ONSIGHT AND DEATH <i>1 hour</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Sat and rode in very hot sun all afternoon Temperature between 95 - 100° F.</i>				
20c. TIME OF INJURY Hour o. n. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>about home</i>	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <i>6/6/57</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Richard Reeler</i>	ADDRESS (Street, city or town, state) <i>8 Hanover St Annapolis, Md</i>			DATE SIGNED <i>6/24/57</i>		
PHYSICIAN'S NAME (Type) <i>Bernard Hardy Holcomb</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/20/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>CARTERS</i>	22d. LOCATION (City, town, or county) <i>Friendship Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardy Holcomb</i>	ADDRESS <i>100 - 6th Street</i>	24a. REC'D BY REGISTRAR DATE <i>6/25/57</i>		24b. REGISTRAR'S SIGNATURE <i>John J. French</i>		

CERTIFICATE OF SERVICE

BUREAU V. S.

JUN 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

105855

5890

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riva</i>		c. LENGTH OF STAY IN 1b <i>—</i>		c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Glen Burnie - Harundale</i>		d. STREET ADDRESS <i>1903 Edgely Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION— <i>Tiverton Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Cora</i>		Firg. <i>B.</i>	Middle <i>Cook</i>	Last <i>—</i>	4. DATE OF DEATH <i>June 16, 1957</i>	Month <i>June</i>	Day <i>16</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 23, 1892</i>	9. AGE (In years last birthday) <i>64</i>	IF UNDER 1 YEAR Months <i>—</i>	IF UNDER 24 HRS. Days <i>—</i>	Hours <i>—</i>	Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework (etc.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Ike Britt</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lilly</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Maj. Wm. McNabb</i>		Address <i>Same as #2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		DUE TO <i>cerebral hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		(b) DUE TO <i>arteriosclerosis &amp; hypertension</i>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>447X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Jan 15, 1957</i> , to <i>June 16, 1957</i> , that I last saw the deceased alive on <i>June 15, 1957</i> , and that death occurred at <i>2:20 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. Borssuck</i> PHYSICIAN'S NAME (Type) <i>S. Borssuck, M.D.</i>		ADDRESS (Street, city or town, state) <i>Baltimore, Maryland</i> DATE SIGNED <i>6/16/57</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/19/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cem.</i>		22d. LOCATION (City, town, or county) <i>Brooklyn Rd., Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>T. J. Funches</i>		ADDRESS <i>Glen Burnie, Md.</i>		24d. REC'D. BY REGISTRAR DATE <i>JUN 20 1957</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Funches</i>		

## CERTIFICATE OF DEATH

NAME

DEATH NO. 1000000000000000000

ST. MARY'S COUNTY, MARYLAND, U.S.A.

NAME

DEATH NO. 1000000000000000000

BUREAU V. S.

JUN 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5848

## CERTIFICATE OF DEATH

05856  
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNEXX Annapolis 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville 16 X 12 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edna Gouthro	Middle Gertrude	4. DATE OF DEATH Month 6 - Day 12 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH Sept. 9, 1891	9. AGE (in years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Hutchison		14. MOTHER'S MAIDEN NAME Maggie Windsor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----- 17. INFORMANT George H. Richards - Mitchellville, Md. Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 780.0		INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO unknown Coma			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12-1957 to 6-12-1957 that I last saw the deceased alive on 6-12-1957, and that death occurred at 2:35 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Shipley		ADDRESS (Street, city or town, state) 630-11-a-8 Ave DATE SIGNED 6-12-57	
PHYSICIAN'S NAME (Type) Frank M. Shipley		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/57	
22c. NAME OF CEMETERY OR CREMATORIUM Epiphany Cemetery		22d. LOCATION (City, town, or county) Forestville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		24a. REC'D. BY REGISTRAR JUN 14 1957	
ADDRESS Upper		24b. REGISTRAR'S SIGNATURE J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MANHATTAN-STATE DEPARTMENT OF HEALTH-ARMED FORCES

## CERTIFICATE OF DEATH

100-8

RECEIVED  
BUREAU V. S.  
JUN 14 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05857

5849

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <i>x Hall Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. General</i>	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>C</i>	Last <i>Cox</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>18</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-1900</i>
9. AGE (In years last birthday) <i>57 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lunch Room</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Lunch Room</i>	11. BIRTHPLACE (State or foreign country) <i>Dunn N.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>N. S. A.</i>
13. FATHER'S NAME <i>John C. Cox</i>	14. MOTHER'S MAIDEN NAME <i>Rose C. Carson</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>931.9</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>R. J. Brown Jr. 2216 Old Snow Hill Road</i>	Address <i>Henston N.C.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Heart Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i></i>		
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/18</i> , 19 <i>57</i> , to <i>6/18/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/18</i> , 19 <i>57</i> , and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Edward G. Gordan M.D.</i>			
ACTUAL SIGNATURE <i>Edward G. Gordan M.D.</i>	PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-21-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Green Wood</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor Sons</i>	ADDRESS <i>Annapolis Md.</i>	24a. REC'D BY REGISTRAR DATE <i>4/21/57</i>	24b. MORTGARER'S SIGNATURE <i>v. French</i>

24 JAN 1957

REGELYÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05858

5891

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchton</i>	c. LENGTH OF STAY IN 1b <i>Churcton</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchton</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Beatrice Cowner</i>	First <i>B</i>	Middle <i>E</i>	Last <i>Cowner</i>			
4. DATE OF DEATH <i>6 18 1957</i>	Month <i>6</i>	Day <i>18</i>	Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR FACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-27-1882</i>			
9. AGE (In years lost birthday) yrs. <i>74</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Churchton, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Joseph Brown</i>	14. MOTHER'S MAIDEN NAME <i>Mary Francis Holland</i>	Address <i>David Brown Churchton, Md.</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; rank or grade) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i></i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>443X</i> <i>Arterio sclerotic Hypertension</i> DUE TO (b) (c) <i>Cardio vascular disease</i>	INTERVAL BETWEEN ONSET AND DEATH <i>6/18/57</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. B. Birkhead</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. <i></i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. B. Birkhead</i>		ADDRESS (Street, city or town, state) <i>M.D. 110-Clay St Baltimore</i>		DATE SIGNED <i>6/18/57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 6-22-57</i>	22b. DATE THEREOF <i>6-22-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Brown</i>	22d. LOCATION (City, town or county) <i>Churchton, Md.</i>	(State) <i></i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Please Jr - Churchton, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>Deb C. L.</i>	DATE UN 20 '57		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DIVISION OF HEALTH - DEATH CERTIFICATE

CERTIFICATE OF DEATH

NAME UNKNOWN

DEATH DATE UNKNOWN

NAME UNKNOWN

BUREAU V. S.

JUN 21 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transt permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05859			
5850 CERTIFICATE OF DEATH										Reg. Dist. No. 21			
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>					b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Maryland</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Annapolis, Md.</b>					d. STREET ADDRESS <b>64 South Gate Avenue</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Pasquale</b>					First <b>(n)</b>	Middle <b>DE SANTIS</b>	Last	4. DATE OF DEATH	Month <b>June</b>	Day <b>13</b>	Year <b>19 57</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 Aug 1861</b>	9. AGE (In years lost birthday) <b>95</b>	IF UNDER 1 YEAR yrs. Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MIC USN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>			11. BIRTHPLACE (State or foreign country) <b>Italy</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Antonio DESANTIS</b>					14. MOTHER'S MAIDEN NAME <b>Domenica MAZZA</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>3-7-93/1-4-1923</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>U. S. Naval Hospital Annapolis, Maryland</b>			
Address										INTERVAL BETWEEN ONSET AND DEATH <b>In excess of 4 years</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>													
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month <b>19</b>	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Annapolis</b>	(County) <b>Maryland</b>	(State) <b>Maryland</b>				
21. I certify that I attended the deceased from <b>20 May</b> , 1957, to <b>13 June</b> , 1957, that I last saw the deceased alive on <b>13 June</b> , 1957, and that death occurred at <b>8:00A</b> M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <b>M. J. Miller</b>										DATE SIGNED <b>13 June 1957</b>			
PHYSICIAN'S NAME (Type) <b>M. J. MILLER LT MC USNR</b>										U.S. Naval Hospital, Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>			22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>			(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>										ADDRESS <b>Annapolis, Maryland</b>			
24a. REC'D BY REG. OFFICE <b>JUN 14 1957</b>										24b. REGISTRAR'S SIGNATURE <b>J. French</b>			
VS A15 (4) 15M 9/55													

## CERTIFICATE OF DATA

SEARCHED	INDEXED
SERIALIZED	FILED
JUN 14 1957	
FBI - HONOLULU	
RECEIVED	

BUREAU V. S.

JUN 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 5851 CERTIFICATE OF DEATH

05860

Reg. Dist. No.

21

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be turned with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deverna Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. Gen Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Arnold S. Dibbs</i>		First	Middle
4. DATE OF DEATH <i>6-19</i>		Last	Month <i>6</i> Day <i>19</i> Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-28-78</i>
9. AGE (In years last birthday) <i>79</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Office</i>	11. BIRTHPLACE (State or foreign country) <i>M.D.</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MÄDEN NAME <i>Geoghegan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Family - Son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Infarction</i> DUE TO <i>592X</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> (c) <i>Arteriosclerotic vascular disease</i> DUE TO <i>Chr. nephritis</i> yrs. yrs. <i>592X</i>			
58. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bleeding from intestinal obstruction with gangrene</i> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/12/57</i> , 19 <i>57</i> , to <i>6/19</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/19</i> , 19 <i>57</i> , and that death occurred at <i>7:35 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>31 Smith Street</i> <i>6/20/57</i> DATE SIGNED <i>6/20/57</i> ACTUAL SIGNATURE <i>Maurice F. Klawans, M.D.</i> PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS, M.D.</i> ADDRESS <i>Baltimore, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-22-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home, 128 E. Fort Ave.</i>		ADDRESS <i>Baltimore, Md.</i>	
24a. REC'D BY REGISTRAR <i>JUN 21 1957</i>		24b. REGISTRAR'S SIGNATURE <i>John J. French</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 05861			
Item 12 Film G217 6-24-57 et Anne Arundel CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY 30 Mansion Rd. Linticum Heights MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Anne Arundel b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linticum Heights X2											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 30 Mansion Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ellis		First		Middle		Last		4. DATE OF DEATH June 17 1957		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16 1888		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Retired				10b. KIND OF BUSINESS OR INDUSTRY Tailor Shop				11. BIRTHPLACE (State or foreign country) Cesena-Teramo-Italy				12. CITIZEN OF WHAT COUNTRY? Italy			
13. FATHER'S NAME Luigi Di Carlo								14. MOTHER'S MAIDEN NAME Maria Emilia Franco							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-09-8202A				17. INFORMANT Salvatora Di Carlo				Address 30 Mansion Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) 156.1 DUE TO <i>Carcinoma of liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cirrhosis - Portal, of liver</i> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 5 mos. 15 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus, myocardial infarction</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>51</u> , to <u>6-17-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-17-57</u> , 19 <u>57</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <u>5907 GWYNN OAK AV.</u>		DATE SIGNED <u>6-18-57</u>	
ACTUAL SIGNATURE <u>Leon Ashman</u>		PHYSICIAN'S NAME (Type) Leon Ashman		M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 20 1957		22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral		22d. LOCATION (City, town, or county) Baltimore Md.		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank DeLoach</u>		ADDRESS 322 S. High St.		24a. REC'D BY REGISTRAR DATE JUN 19 1957		24b. REGISTRAR'S SIGNATURE <u>Quinton</u>									
VS A15 (4) 15M 9/55															

SURÉAU V. S.

1951 JUN 19

PEGEIV E

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05862

25

5893

Anne Arundel

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... 100 Cepplin Ave  
 City or town... Petaplaces Park Arundel Co.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years  
 Hospital, Institution, or street address where death occurred:  
 100 Cepplin Ave

How long in hospital or institution?

## 3. (a) FULL NAME

EMANIA E. D' 995

4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced

Female | Cf | Widower

6. (b) Name of husband or wife Frank D'igges

Deceased - 6. (c) If alive, give age years  
 7. Birth date of deceased (mo. day, yr.)8. AGE: Years Months Days If less than one day  
 84 23 hrs. min.

9. Birthplace Mathews Co. Va.

(Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

None

12. Name Fredrik White

13. Birthplace Mathews Co. Va.

14. Maiden name Mary D'igges

15. Birthplace Mathews Co. Va.

16. Informant Mrs. Ethel Clarke

Address 2230 Madison Ave Baltimore

17. Burial Date thereof 6-16-57  
(Burial, cremation, or removal) Which?

(month) (day) (year)

Cemetery or crematory Sugar Hill Cemetery

Location Mathews Co. Va.

18. Funeral director Mrs. Joseph A. Lively

Address 661 West Bayre St. Baltimore

19. 6/13/57 19 (Date rec'd by registrar)

Signature John H. Hedrick

Signature J. H. Hedrick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Arundel Co.

City or town... (If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Cepplin Ave X  
If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

NONE

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11-57 19 al M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-6-53 19, to 6-11-57 19

and that I last saw her alive on 6-11-57 19

Immediate cause of death AORTIC STENOSIS -

PNEUMONIA. DURATION ?  
 1 MONTH

Due to HYPERTENSION -

Due to MYOCARDIAL INFARCTION ?

Other conditions 4-11-1

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Long G. Hamm, M.D. M. D. or other

Address 2224 Modern Rd. Date signed 6-12-57

BUREAU V. S.

JUN 17 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5852 CERTIFICATE OF DEATH

05863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	A. A. Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	Md		b. COUNTY	a.a	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
ANNAPOLIS						Orchard BEACH	x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	H.A. GENERAL Hospital		d. STREET ADDRESS	7925 GREEN DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
male	ELMER	R.	Disney	June	3		1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
	white		JAN 22, 1905	77 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
hair dresser	Chemical Co	WASH DC.						
13. FATHER'S NAME	William T. Disney		14. MOTHER'S MAIDEN NAME	HESTER E Batchelor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address					
NO	115-05-1412	Wm. H. Disney	109 Kingsway Dr. BALTIMORE Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
420.1 DUE TO coronary occlusion								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO coronary heart disease						2 yrs		
(c) DUE TO arteriosclerosis pern.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
19								
21. I certify that I attended the deceased from 6-1, 1957, to 6-3, 1957, that I last saw the deceased alive on 6-2, 1957, and that death occurred at 5 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
						DATE SIGNED		
ACTUAL SIGNATURE	Edith Roder		M.D.		45 Franklin St. Homesp's Med.			
PHYSICIAN'S NAME (Type)	EDITH RODLER M.D.		45 Franklin St. Homesp's Med.		6-3-57			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)				
BURIAL	6-6-1957	GLEN HAVEN CEM	A. A. Co	Md				
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	PAUL + STRICKERS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE			
ROBERT B. McWILLIAMS		MDA		1957	John J. French			
VS A15 (4) 15M 9/55								

## MARYLAND STATE DEPARTMENT OF GENERAL SITUATION

## CERTIFICATE OF DEATH

NAME	NAME
ADDRESS	ADDRESS
AGE	AGE
SEX	SEX
DEATH DATE	DEATH DATE
CAUSE OF DEATH	CAUSE OF DEATH
TIME OF DEATH	TIME OF DEATH
PLACE OF DEATH	PLACE OF DEATH
DEATH CERTIFIED	DEATH CERTIFIED
RECEIVED	RECEIVED
BUREAU V.	BUREAU V.
REC'D BY	REC'D BY
DATE	DATE
INITIALS	INITIALS

JUN 4 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10176 21

Item 14 Film G221 10-15-57 et

Reg. Dist. No.

9036									
1. PLACE OF DEATH a. COUNTY A.M.CO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE PA		b. COUNTY MONTG.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pottstown		75x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL		d. STREET ADDRESS 327 GRANT ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Henry Middle W. DOZIER		Last DOZIER		4. DATE OF DEATH 6 15 1957					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday) 36 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR Dept		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Douglass - 9A		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William DOZIER		14. MOTHER'S MAIDEN NAME Barbara Johnson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH Sudden									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Swimming College Creek Annapolis Md							
20c. TIME OF INJURY Month, Day, Year Hour p.m. 6-18-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) College Creek Annapolis MD		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE E. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 6/18/57	
EXAMINER'S NAME (Type) E. Linhardt		22b. DATE THEREOF 6-19-57		22c. NAME OF CEMETERY OR CREMATORIAL 2nd Baptist		22d. LOCATION (City, town, or county) Pottstown - Montg. Penn.		(State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. ADDRESS 726 High St		24a. REC'D BY REGISTRAR 10/7/57		24b. REGISTRAR'S SIGNATURE Mr. French			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth M. Dauchman		ADDRESS Mills Lavor		DATE					

BUREAU V. S.  
RECEIVED  
OCT 8 1957

WISCONSIN STATE BOARD OF HEALTH  
MEDICAL EXAMINER CERTIFICATE OF DEATH

STATE  
WISCONSIN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5853

## CERTIFICATE OF DEATH

05864

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		b. COUNTY		Q	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x2 Neems Creek		d. STREET ADDRESS		97 F D Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First /	Middle	4. DATE OF DEATH	Month	Day	Year				
Female White		Anne	Maria	Dulin	6	11	1957				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		
House wife				Sept 3-1888		68					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Perkins J. Shaw		Home		Queen Ann Co Md		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Wilbur P. Dulin Arnold		Sarah Hoffacker									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
+ + +				Wilbur P. Dulin		420.1 Myocardial infarction Coronary Thrombosis		7 days 2 wks.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
19											
21. I certify that I attended the deceased from <u>5-1</u> , 19 <u>57</u> , to <u>6-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-11-57</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>James R. Martin</u>		M.D.									
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-57</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>6/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Smith</u>					

## CERTIFICATE OF DEATH

WITNESSED

BUREAU V. S.

JUN 17 1957

REGELIVE

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

05865

**5894 CERTIFICATE OF DEATH**

Reg. Dist. No. 34

**1. PLACE OF DEATH**

COUNTY

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Anne Arundel

MARYLAND

LENGTH OF STAY  
(In this place)

Glen Burnie

Plaza Manor Condo, Home

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE

Md.

COUNTY

AA.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET  
ADDRESS

Glen Burnie

(If rural give location)

Oakwood Rd, RFD #1

**3. NAME OF  
DECEASED  
(Type or Print)**

(First)

(Middle)

(Last)

CATHERINE FLEAGLE

**5. SEX**

F

**6. COLOR OR  
RACE**

W

**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)**

SINGLE

**10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)****13. FATHER'S NAME**

UNKNOWN

**10b. KIND OF BUSINESS  
OR INDUSTRY**

Machine Operator

**11. BIRTHPLACE (State or foreign country)**

Natl' Plastic Union Bridge Md

**14. MOTHER'S MAIDEN NAME**

UNKNOWN

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**

(Yes, no, or unk.) (If Yes, give war or dates of service)

NO NONE

**16. SOCIAL SECURITY NO.**

218-03-8708 MRS SAMUEL CHALFANT, Gambier, Md.

**17. INFORMANT & ADDRESS**INTERVAL BETWEEN  
ONSET AND DEATH**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

331X IMMEDIATE CAUSE (A) CEREBROVASCULAR ACCIDENT

ANTECEDENT CAUSE(S) DUE TO HYPER TENSION

DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**

353.5 EPILEPSY

**19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES  NO **21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)  
(County) (State)**

102 Bally-Garrison Rd, Glen Burnie, Md.

DATE SIGNED 6-20-57

**21d. TIME OF INJURY (Month) (Day) (Year) (Hour)**M. While at work  Not while at work **21e. INJURY OCCURRED**

10 AM

**21f. HOW DID INJURY OCCUR?**

Hopping + Kirkley, Glen Burnie

**22. I hereby certify that I attended the deceased from**

Jan 19, 1955 to June 19, 1957

that I last saw the deceased

alive on June 10, 1957 and that death occurred at 10 AM, from the causes and on the date stated above.

SIGNATURE Joseph Taler

ADDRESS 102 Bally-Garrison Rd, Glen Burnie, Md.

DATE SIGNED 6-20-57

**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)**

BURIAL

**DATE THEREOF**

6/21/57

**NAME OF CEMETERY OR CREMATORIUM**

GLEN HAVEN

**LOCATION (City, town, or county) (State)**

GLEN BURNIE, MD.

**24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE**

L. J. Kelley

**25. FUNERAL DIRECTOR'S SIGNATURE**

Hopping + Kirkley, Glen Burnie

ADDRESS

JUN 24 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5895 CERTIFICATE OF DEATH

05866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Anne Arundel MARYLAND</i>		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Pasadena 4 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Poplar Ridge Rd Rt 2 Box 273</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>	
d. STREET ADDRESS <i>Poplar Ridge Rd Rt 2 Box 273</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Louise</i>	Middle <i>C.</i>	Last <i>Zlory</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>5</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/26/1889</i>
Female	white		9. AGE (In years last birthday) yrs. <i>67 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>John L. Schmitt</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>✓</i>	16. SOCIAL SECURITY NO. <i>✓</i>	17. INFORMANT <i>Mr Fred W. Bradbury</i>	Address <i>Poplar Ridge Rd. Box 273</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. <i>(b)</i>		Myocardial Failure (auto) instant	
DUE TO <i>Hyper tension arterio-sclerotic C.V.D.</i>		20 yrs.	
DUE TO <i>(c)</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1, 1956</i> , to <i>June 5, 1957</i> , that I last saw the deceased alive on <i>June 4, 1957</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>D.T. Battaglia</i>		ADDRESS (Street, city or town, state) <i>5829 Belair Rd - 6/5/57</i>	
PHYSICIAN'S NAME (Type) <i>D.T. BATTAGLIA</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/9/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cem.</i>	22d. LOCATION (City, town, or county) <i>3801 Frederick Rd.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Brown &amp; Son</i>	ADDRESS <i>921 Clarks St.</i>	24a. REC'D BY REGISTRAR <i>JUN 7 1957</i>	24b. REGISTRAR'S SIGNATURE <i>L. J. DeSlo</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MANHATTAN STATE PENITENTIARY - BUREAU OF REVENGE

## CERTIFICATE OF DEATH

DECEASED

BUREAU V. 5

JUN 7 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 05867 28	
Item 7 Film G216 6-14-57 et CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN lb <b>3yrs, 10mos. 18days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> 14372 ✓						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>					d. STREET ADDRESS <b>105 College Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Frank</b>	Middle <b>Edward</b>	Last <b>Gardner</b>	4. DATE OF DEATH	Month <b>6</b>	Day <b>7</b>	Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>8/1/92</b>			9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Frank Gardner</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Brown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Nervous System Syphilis</b>										INTERVAL BETWEEN ONSET AND DEATH	
026 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } lying cause last. } (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gluteal Decubiti</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>7/20</b> , 1953, to <b>6/7</b> , 1957, that I last saw the deceased alive on <b>6/6</b> , 1957, and that death occurred at <b>2:30a.m.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	
ACTUAL SIGNATURE <i>Benedict</i> M.D.										DATE SIGNED <b>6/7/57</b>	
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Janes Cem. (6/9/57)</b>		22d. LOCATION (City, town, or county) <b>Chestertown, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Walley</i>		ADDRESS <b>Chestertown Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 1957</b>		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>					
VS A15 (4) 15M 9/55											

CERTIFICATE OF DEATH

REG. NO. 1057

BUREAU Y. S.

JUN 10 1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05868  
38

5897

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3 yrs. 6 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
3. NAME OF DECEASED (Type or print) First Willie Middle		d. STREET ADDRESS Paca Street	
4. DATE OF DEATH Last Gray Month 6 Day 15 Year 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 78? yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY — — —	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U. S.	
12. FATHER'S NAME Andrew Gray		13. MOTHER'S MAIDEN NAME Willie Gray	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		15. SOCIAL SECURITY NO. Unk.	
16. INFORMANT Hospital Records		17. CROWNSVILLE STATE HOSPITAL Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5 1956 to 6/15 1957, that I last saw the deceased alive on 6/12 1957, and that death occurred at 5:20 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i> PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-57	
22c. NAME OF CEMETERY OR CREMATORIAL Crownsville Hospital		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Keeler #108 W. Wash. St. Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 6/21/57	
24b. REGISTRAR'S SIGNATURE John Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director.

WISCONSIN STATE DEPARTMENT OF HEALTH - JUNIOR HOME

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
JUN 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5898

## CERTIFICATE OF DEATH

0586928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2 yrs. 2 mos. 11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		d. STREET ADDRESS <b>Not given</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Not given</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Lena</b>	Last <b>Gross</b>	4. DATE OF DEATH Month <b>6</b>	Month <b>Day</b> <b>15</b>	Day <b>Year</b> <b>19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not given</b>	9. AGE (In years last birthday) <b>77? yrs.</b>	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —	Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Not given</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Not given</b>		14. MOTHER'S MAIDEN NAME <b>Not given</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH						
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b>								
DUE TO  (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>522X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>12/2</b> , 19 <b>57</b> , to <b>6/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/18</b> , 19 <b>57</b> , and that death occurred at <b>7:35 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>6/16/57</b>						
ACTUAL SIGNATURE <i>Karen McHenry Mapp</i>		M.D.						
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>								
22a. BURIAL/CREMATION REMOVAL (Specify) <b>Anne Arundel</b>		22b. DATE THEREOF <b>6-20-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>C. of M. Medical Center Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reesett</i>		ADDRESS <b>108 W. Washington St.</b>		24a. REC'D BY REGISTRAR DATE <b>6/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. M. Joyce</b>		

WISCONSIN STATE GOVERNMENT - DIVISION OF  
CERTIFICATE OF DEATH

BUREAU V. S.

JUN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05870  
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>15 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle <b>VIRGINIA</b>	Last <b>HAROLD</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>26</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/23/1921</b>
9. AGE (In years last birthday) <b>35</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Lcs. &amp; M. made Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vernon Woodard</b>		14. MOTHER'S MAIDEN NAME <b>Clara Dodson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. John H. Harold Jr., Worcester Rd.		Address <b>4425 FORRESTER RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b>			
DUE TO 981X			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by assailant</b>	
20c. TIME OF INJURY Hour <b>4</b> p. m.		Month, Day, Year <b>6/26 1957</b>	
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>	
20f. (City or town) <b>Anne Arundel</b>		(County) <b>Md.</b>	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		DATE SIGNED <b>6/27/57</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Glen Haven Cem. 901 Collins St.</b>		22d. LOCATION (City, town, or county), (State) <b>Bethel Hwy Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. French</i>		REC'D BY REGISTRAR DATE <b>JULY 1 1957</b>	
		24b. REGISTRAR'S SIGNATURE <i>John J. French</i>	

**RECEIVED**

JUL 1 1957

**BUREAU V.**

Original record of page

Original record of page

STATE OF HAWAII - GOVERNOR'S OFFICE  
EXAMINER'S CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5899 CERTIFICATE OF DEATH

05871

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. LENGTH OF STAY IN 1b <i>3 mo 210</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Beth 210</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Wesley</i>	Last <i>Harris</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>14</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OF RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-17-1891</i>
9. AGE (In years last birthday) <i>66 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Samuel W. Harris</i>	14. MOTHER'S MAIDEN NAME <i>Malinda Galloway</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>213-05-2605</i>	17. INFORMANT <i>Mary E. Harris - Edgewater, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arterio sclerosis Hypertension Cardio</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>443X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>110-Chey St Indianapolis, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 15, 1957</i> to <i>6/14/57</i> , that I last saw the deceased alive on <i>6/14/57</i> , and that death occurred at <i>12:15 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. L. Richardson</i>			
ADDRESS (Street, city or town, state) <i>110-Chey St Indianapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 6-16-57</i>		22b. DATE THEREOF <i>6-16-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Hopet Chapel Edgewater, Md.</i>
22d. LOCATION (City, town, or county) <i>(State)</i>		22e. REC'D BY REGISTRAR <i>JUN 20 1957</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Seest - Anna, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - CERTIFICATE OF DEATH  
STATE OF GEORGIA - ATLANTA

BUREAU V. S

JUN 21 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5900

## CERTIFICATE OF DEATH

05872  
78

Reg. Dist. No.

M

10

I

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2yr. 9mos. 21days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3V26-4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>1731 E. Biddle Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Richard</b>		First	Middle	Last	4. DATE OF DEATH <b>Harris</b>	Month <b>6</b>	Day <b>7</b>	Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/10/29</b>	9. AGE (In years lost birthday) <b>27 yrs.</b>	IF UNDER 1 YEAR Months <b>-</b>	IF UNDER 24 HRS. Days <b>-</b>	Hours <b>-</b>	Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Shine Boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Not given</b>		14. MOTHER'S MAIDEN NAME <b>Not given</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Unk. Hospital Records</b>		Crownsville State Hospital Address <b>Crownsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage of the lung</b>		INTERVAL BETWEEN ONSET AND DEATH							
DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Tuberculosis of the lungs							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Crownsville, Md.</b>		(State)	
21. I certify that I attended the deceased from <b>8/17</b> , 19 <b>54</b> , to <b>6/7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/7</b> , 19 <b>57</b> , and that death occurred at <b>3:50 p.m.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>							DATE SIGNED <b>6/7/57</b>
ACTUAL SIGNATURE <i>Ludwig Benedict</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Galway</b>		22d. LOCATION (City, town, or county) <b>A. A. County, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Randolph Bollick</i>		ADDRESS <b>1111 E. Preston St.</b>		24a. REC'D BY REGISTRAR DATE <b>6/14/57</b>		24b. REGISTRAR'S SIGNATURE <i>E. M. Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
CERTIFICATE OF DEATH

DO NOT FILE

BUREAU V. 8

JUN 17 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05873  
*34*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point Pleasant, Glen Burnie		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marley Creek		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights	
3. NAME OF DECEASED (Type or print) Edmund Joseph Harvey		d. STREET ADDRESS 606 Camp Meade Rd.	
4. DATE OF DEATH June 17th.	Month June	Day 17	Year 1957
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH 8/24/11
8. AGE (In years last birthday) 45 yrs.	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Harvey		14. MOTHER'S MAIDEN NAME Sarah Kenline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) National Guard.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dora Harvey (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning DUE TO 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO c PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowning	
20c. TIME OF INJURY Hour 7.45 a. m. p. m. 6/17/57 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marley Creek
20f. (City or town) Point Pleasant, A.A. Md.		(County) Md.	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 17th. 1957.	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glen Haven Memorial		22d. LOCATION (City, town, or county) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>		24a. REC'D BY REGISTRAR DATE JUN 20 1957	
		24b. REGISTRAR'S SIGNATURE <i>L.Y. DeAlba</i>	

WEDNESDAY, JUNE 20, 1957  
RECEIVED - EXHIBIT NO. 8  
KANSAS STATE DEPARTMENT OF HIGHLIGHTS

BUREAU U.S.  
RECEIVED  
JUN 20 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5902

## CERTIFICATE OF DEATH

05874

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3 vol - 4 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>1419 N. Bond Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Ella</b>	Middle <b>Elstine</b>	Last <b>Esteon</b>	4. DATE OF DEATH <b>6</b>	Month <b>6</b>	Day <b>28</b>	Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/22/04</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months <b>-</b>	IF UNDER 24 HRS. Days <b>-</b>	Hours <b>-</b>	Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Not given</b>			14. MOTHER'S MAIDEN NAME <b>Not given</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		State Hospital Address <b>Crownsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cerebral Thrombosis</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anemia, Syphilis</b>								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. s. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>6/14</b>	(County) <b>19 57</b>	(State) <b>6/28</b>	
21. I certify that I attended the deceased from alive on <b>6/28</b> , 19 57, and that death occurred at <b>10 a. M.</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>	ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>6/28/57</b>							
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/30/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary</b>	22d. LOCATION (City, town, or county) <b>Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. O. Wilson (PAH)</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>JUL 2 1957</b>	24b. REGISTRAR'S SIGNATURE <i>H. M. Joyce</i>				

WISCONSIN STATE BOARD OF HEALTH - BUREAU OF

CERTIFICATE OF DEATH

NAME  
ADDRESS  
CITY, STATE, ZIP

NAME  
ADDRESS  
CITY, STATE, ZIP

DECEASED

DECEASED

BUREAU V. S.

JUL 2 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5903

## CERTIFICATE OF DEATH

05875

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore City</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>12 yrs. 6 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>		3 V O I - 4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>				d. STREET ADDRESS <i>1634 Ellsworth Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Samuel</i>	Middle <i></i>	Lost <i>Henry</i>	4. DATE OF DEATH <i>6 29 1957</i>	Month <i>6</i>	Day <i>29</i>	Year <i>1957</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/10/35</i>	9. AGE (In years last birthday) <i>22</i> yrs.	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Never employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			
13. FATHER'S NAME <i>John Adams</i>				14. MOTHER'S MAIDEN NAME <i>Sophie Henry</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hospital Records</i>		Crownsville State Hospital Address Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Epileptic seizure</i>						INTERVAL BETWEEN ONSET AND DEATH			
353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)									
DUE TO <i>Epilepsy</i> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from alive on <i>6/29 1957</i> , and that death occurred at <i>10:50 A.M.</i> from the causes and on the date stated above.				1/21 1948 to 6/29 1957					
ACTUAL SIGNATURE <i>Ludwig Benedict</i>				ADDRESS (Street, city or town, state) <i>Crownsville, Md.</i>		DATE SIGNED <i>6/29/57</i>			
PHYSICIAN'S NAME (Type) <i>Ludwig Benedict, M. D.</i>									
22a. BURIAL, CREMATION, REMAINT (Specify) <i>7/5/57</i>		22b. DATE THEREOF <i>7/5/57</i>		22c. NAME OF CEMETERY OR CREMATORIY <i>Mt. Calvary Cemetery</i>		22d. LOCATION (City, town, or county) <i>A. A. Co. Md.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymer Sanders</i>		ADDRESS <i>2148 Piedmont</i>		24a. REC'D BY REGISTRAR DATE <i>7/3/57</i>		24b. REGISTRAR'S SIGNATURE <i>Kathleen Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

15 =

BUREAU V. S.

JUL 3 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5855

## CERTIFICATE OF DEATH

05876

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Harwood</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>/ --</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>B.</b>	Last <b>Hereford</b>	4. DATE OF DEATH	Month <b>6</b>	Day <b>28</b>	Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>June 1, 1886</b>	9. AGE (In years, months, days) lost (birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employd. Manager.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Richard West Hereford</b>				14. MOTHER'S MAIDEN NAME <b>Kate M. Mitchell-Moore</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Katherine Clagett-</b>		Address <b>Harwood, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, lobar</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic bronchitis</b> DUE TO (c) <b>Asthma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>241X Old Craniotomy</b>									INTERVAL BETWEEN ONSET AND DEATH <b>3days</b> <b>1month</b> <b>15 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <b>-----</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. p.m. 19	Month a. jn. 19	Day Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) <b>-----</b>	(County) <b>-----</b>	(State) <b>-----</b>			
21. I certify that I attended the deceased from <b>1950</b> , <b>19</b> , to <b>28 June, 1957</b> , that I last saw the deceased alive on <b>28 June, 1957</b> , and that death occurred at <b>4:40 PM</b> , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>Shady Side, Maryland</b>	DATE SIGNED <b>6/27/57</b>
ACTUAL SIGNATURE <b>F.D. Hendricks</b>	M.D.									
PHYSICIAN'S NAME (Type) <b>F.D. Hendricks</b>	Shady Side, Maryland.									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/1/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity Cemetery</b>		22d. LOCATION (City, town, or county) <b>Upper Marlboro</b>		(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>			ADDRESS <b>-----</b>	24a. REC'D BY REGISTRAR <b>2 1057</b>	24b. REGISTRAR'S SIGNATURE <b>J. F.</b>					

## CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
JUL 2 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5994

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05877

Reg. Dist. No. 24

Item 8 Film G217 7-5-57 et.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		d. Name of Hospital or Institution (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Baltimore Maryland</i>				b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Hunters Harbor</i>				<i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		<i>8018 Luzern Ave</i>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
<i>John</i>				<i>Holman</i>	6 29 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.
<i>M.</i>		<i>W</i>		<i>Sept. 28, 1886</i>	<i>1905 51</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (State or foreign country)	
		<i>Boiler Maker</i>		<i>Baltimore</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>John Holman</i>		<i>Mary A. Hatchell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				<i>Francis Holman Wife</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Disease</i> DUE TO					
42a. 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E. Linhardt</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		629.57			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 2/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Stanislaus</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. Ozanowski</i>		ADDRESS <i>1930 Eastern Ave</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 1 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>L. J. Dealtas</i>	

WISCONSIN STATE EXAMINER'S CREDIT EXAMINEE OF DEATH

WISCONSIN STATE EXAMINER'S CREDIT EXAMINEE OF DEATH

BUREAU-Y. S.

JUL 1 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5905

## CERTIFICATE OF DEATH

Q5878

28

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Gambrills</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Gambrills</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 81, Gambrills, Md.</i>		e. STREET ADDRESS <i>#5 Waugh Chapel Rd</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Adice Bristol Honor</i>		First	Middle	Last	4. DATE OF DEATH <i>June 13 1957</i>
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1, 1881</i>	9. AGE (In years last birthday) yrs. <i>75</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (40-)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>	
12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		13. FATHER'S NAME <i>Dennet I. Bristol</i>		14. MOTHER'S MAIDEN NAME <i>Henretta Swift</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - -</i>		17. INFORMANT <i>Pau Irving Honor Sr., Gambrills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line] for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO <i>Pulmonary Edema</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b) Pulmonary Edema</i> DUE TO <i>(c) Coronary Thrombosis</i>				3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sensitivity</i>				3 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. — p. m. —		Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from <i>11/4 1949</i> to <i>6/13 1957</i> , that I last saw the deceased alive on <i>6/5 1957</i> , and that death occurred at <i>10:21 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. W. Prichard</i> PHYSICIAN'S NAME (Type) <i>R. W. PRICHARD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>June 12, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln</i>	
22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Washington Glen Burnie, Md.</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 18 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGIEAU V. S.

JUN 18 1957

REGIEAU

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 5906 Item 4 Film G217 7-10-57 et  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

05879

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>#310 W. Maple Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights x2</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret H. Hopkins</b>		First	Middle
4. DATE OF DEATH <b>June 30, 1957</b>		Last	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>March 17, 1907</b>		9. AGE (In years last birthday) <b>50</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Luth. Ch.</b>	11. BIRTHPLACE (State or foreign country) <b>Statten Is., N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Louis J. Ullmann</b>	
14. MOTHER'S MAIDEN NAME <b>Minnie Miller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>079 16 6484</b>		17. INFORMANT <b>Mrs. Minnie Ullmann</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>190X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) <b>Carcinoma Rt. Breast with Metastases of the lungs</b> DUE TO (c)		Address <b>27 Brownell st. Statten Is., N.Y.</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.                          19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 24, 1957</b> , to <b>June 30, 1957</b> , that I last saw the deceased alive on <b>June 30, 1957</b> , and that death occurred at <b>10:20P</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. Milton Linthicum</b>		ADDRESS (Street, city or town, state) <b>106 W. Maple Rd.</b> DATE SIGNED <b>7/1/57</b>	
22a. PHYSICIAN'S NAME (Type) <b>C. Milton Linthicum,</b>		Linthicum Heights, Md.	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22c. DATE THEREOF <b>July 5, 1957</b>	
22d. LOCATION (City, town, or county) <b>Statten Island, N.Y.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. S. Johnson</b>		24a. ADDRESS <b>Glen Burnie, Md.</b>	
24b. REG'D BY REGISTRAR DATE <b>JUL 5 57</b>		24c. REGISTRAR'S SIGNATURE <b>A. L. Schenck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. L.

JUL 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10196

## 903 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same		b. COUNTY Same		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn 25</b>		c. LENGTH OF STAY IN 1b <b>9 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 2 Same</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>110 Ordinance Rd.</b>		e. STREET ADDRESS <b>Same</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Christine Birdie Howard</b>		First	Middle	Last	4. DATE OF DEATH <b>June 23rd.</b>	Month	Day	Year <b>19 57</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/18</b>	9. AGE (In years last birthday) <b>39 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elevton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Field Holland</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jennie Cager</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lorraine White (same address)</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO								
{ (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>June 23rd. 1957</b>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/27/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Marley Neck Church Yd.</b>	22d. LOCATION (City, town, or county) <b>Arundel Co. Md.</b>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sarah L. Brown &amp; Son</i>	ADDRESS <b>108 W. MONTGOMERY</b>	24a. REC'D BY REGISTRAR <b>NOV 6 1957</b>	24b. REGISTRAR'S SIGNATURE <i>Ma. Matson</i>					

RECEIVED

BUREAU V. 8

NOV 6 1957

RECORDED IN FILE NO. 123456789

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5856

## CERTIFICATE OF DEATH

05881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>10 days</i>	b. COUNTY <i>AA</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.C. General</i>	d. STREET ADDRESS <i>101 Arehwood Ave</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Douglas Hudgens</i>	First <i>John</i>	Middle <i>Douglas</i>	Last <i>Hudgens</i>
4. DATE OF DEATH <i>6-1-1957</i>	Month <i>6</i>	Day <i>1</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-30-1883</i>
9. AGE (In years lost/birthday) yrs. <i>73</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pet Electric Engineer</i>		11. BIRTHPLACE (State or foreign country) <i>Almond Va</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Perry Hudgens</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Eva G. Hudgens</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>204.3</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 min.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>63 College Ave</i>		20f. (City or town) (County) (State) <i>Annapolis</i>	
21. I certify that I attended the deceased from <i>5/31/1957</i> to <i>6/1/1957</i> , that I last saw the deceased alive on <i>6/1/1957</i> , and that death occurred at <i>6/1/1957</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>63 College Ave</i>			
ACTUAL SIGNATURE <i>Frank M Shipley</i>		DATE SIGNED <i>6/2/57</i>	
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-3-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>6/4/57</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE DATE <i>J. Donald</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5857

Item 9 Film G218 7-18-57 et

05882

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. COUNTY <i>O.W.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>6 months</i>	d. STREET ADDRESS <i>Severna Park, Md.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Lottie B Jackson</i>	First <i>L</i>	Middle <i>ottie</i>	Last <i>B</i>	4. DATE OF DEATH <i>6 18 1957</i>	Month <i>6</i>	Day <i>18</i>	Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Approx. 79 yrs.</i>	9. AGE (In years lost birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>A.A.C. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Tenson Brown</i>	14. MOTHER'S MAIDEN NAME <i>Lottie Brown</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>1</i>	17. INFORMANT <i>Helen Williamson-Sullivan, R.N.</i>	Address <i>Severna Park, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerotic by arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>443X</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>443X</i>								
(b) <i>Thickened disease grade III</i>								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senility, hypertension</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) <i>None</i>	(State) <i>None</i>			
21. I certify that I attended the deceased from <i>5/25/57</i> to <i>6/18/57</i> , that I last saw the deceased alive on <i>6/18/57</i> , and that death occurred at <i>8:45 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.L. Richardson</i>	ADDRESS (Street, city or town, state) <i>M.D. 10-16th St. Annapolis, Md. 21401</i>							
PHYSICIAN'S NAME (Type) <i>William Seese, Jr., C.M.</i>	DATE SIGNED <i>6/19/57</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 6-23-57</i>	22b. DATE THEREOF <i>6-23-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Carpenters Hill</i>	22d. LOCATION (City, town, or county) <i>Fairland Bay, Md.</i>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Seese, Jr., C.M.</i>	ADDRESS <i>None</i>	24a. REC'D BY REGISTRAR <i>JUN 20 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>					

WISCONSIN STATE GOVERNMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

BUREAU V.

JUN 31 1957

REGEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5997

## CERTIFICATE OF DEATH

Reg. Dist. No.

05883  
21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Heights</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>Barleigh Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Comelie</i>	Middle <i>J.</i>	Last <i>Johnson</i>
4. DATE OF DEATH	Month <i>June</i>	Year <i>1957</i>	Day <i>20</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Color</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 16, 1879</i>
9. AGE (In years last birthday) yrs. <i>78</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Cambridge Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Charles Banks (536 Oxford St)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Furhaven</i> DUE TO 204.4 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>62 Cathedral</i> (County) <i>Annapolis</i> (State) <i>Md</i>	
21. I certify that I attended the deceased from <i>10-8-56</i> , 19_____, to <i>6-20-57</i> , 19_____, that I last saw the deceased alive on <i>6-19-57</i> , 19_____, and that death occurred at <i>62 Cathedral</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>62 Cathedral</i> DATE SIGNED <i>6-22-57</i>			
ACTUAL SIGNATURE <i>A.T. Allen</i>		M.D. <i>A.T. Allen</i>	
PHYSICIAN'S NAME (Type) <i>A.T. Allen</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 23/57</i>	
22b. DATE THEREOF <i>June 23/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Church em</i>	
22d. LOCATION (City, town, or county) <i>Barleigh Heights Md</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amelia A. Johnson</i>		24a. REC'D BY REGISTRAR <i>Amables</i>	
ADDRESS <i>Amables</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	
VS A15 (4) 15M 9/55		DATE <i>June 25 1957</i>	

CHIEF OF STAFF  
DEPARTMENT OF DEFENSE

BUREAU V. S.

JUN 25 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05884  
28

5908

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 6 mos. 20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. STREET ADDRESS <b>931 N. Gay Street</b>	
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>Edward</b>
Last <b>Jones</b>		4. DATE OF DEATH <b>6</b>	Month <b>20</b>
		Day <b>19</b>	Year <b>57</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/21/79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Alabama</b>
13. FATHER'S NAME <b>Not given</b>		14. MOTHER'S MAIDEN NAME <b>Not given</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT <b>Hospital Records</b>
		Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Congestive heart failure</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Arteriosclerotic Cardiovascular Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I attended the deceased from <b>12/31</b> , 19 <b>53</b> , to <b>6/20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/18</b> , 19 <b>57</b> , and that death occurred at <b>5:10 p.m.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ludwig Benedict</i>		20f. (City or town) (County) (State)	
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/24/57</b>		22b. DATE THEREOF <b>6/24/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <i>C. J. Brandy</i>		24a. REC'D BY REGISTRAR DATE <b>6/24/57</b>	
		24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i>	

MISSOURI STATE DEPARTMENT OF HEALTH - SALINAS

CERTIFICATE OF DEATH

BUREAU V. A.  
REGISTRY

JUN 25 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5858

## CERTIFICATE OF DEATH

Reg. Dist. No.

05885

1. PLACE OF DEATH a. COUNTY <i>a a</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		b. COUNTY <i>a a</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Turkey Point</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>O. U. General Hospital</i>		d. STREET ADDRESS <i>Edgewater Md</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH <i>6 - 25<sup>th</sup> 1957</i>	
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May-14<sup>th</sup> 1897</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Salsman</i>	
11. BIRTHPLACE (State or foreign country) <i>Brooms Isle Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joshua Wilson Jones</i>		14. MOTHER'S MAIDEN NAME <i>Edith Elizabeth Garner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>World War I</i>	
17. INFORMANT <i>Grace Ellen Jones (2)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422 1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Glaucester Carter Ankylosis. Arterosclerosis Cardio Thascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>451 X</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/23</i> , 19 <i>57</i> , to <i>6/25</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/25</i> , 19 <i>57</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Edward S. Beck</i> M.D. DATE SIGNED <i>Edward S. Beck</i>			
PHYSICIAN'S NAME (Type) <i>Edward S. Beck, M. D.</i>		41 Southgate Ave. Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 27-57</i>		22b. DATE THEREOF <i>June 27-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest</i>		22d. LOCATION (City, town, or county) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>6/28/57</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5999

Item 2 FilmG217 7-5-57 et

(15886) 27

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Ann Arundel County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Meade</b>		c. LENGTH OF STAY IN 1b <b>Unknown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Ft. Meade</b>		d. STREET ADDRESS <b>Ft G G Meade Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Henry</b>		First <b>H.</b>	Middle <b>Krouse</b>	Last <b>18 April 1883</b>	4. DATE OF DEATH <b>June 29 1957</b>	Month <b>July</b>	Day <b>29</b>	Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>18 April 1883</b>	9. AGE (In years less birthday) <b>74</b>	IF UNDER 1 YEAR <b>74</b>	IF UNDER 24 HRS. Months <b>0</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rector-Sexton Synagogue</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA (Wet)</b>			
13. FATHER'S NAME <b>Unkn.</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Krouse</b>		Address <b>Balt 2, Md Mrs Ruth Mills 817 Teawnette Ave</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>331 X</b> 17. INFORMANT <b>Mrs Ruth Mills</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>420.0</b> (b) <b>Previous myocardial infarction</b> DUE TO <b>Cerebrovascular accident</b> (c) <b>Cerebral embolism Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>331 X</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ADDRESS (Street, city or town, state)</b>							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Chicago Ill</b>	(County) <b>Illinois</b>	(State) <b>Ill</b>	
21. I certify that I attended the deceased from <b>29 Jun 1957</b> to <b>29 Jun 1957</b> , that I last saw the deceased alive on <b>29 Jun 1957</b> , and that death occurred at <b>1040 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>John W. Saylor</b> ADDRESS <b>310-1 SUAH FO 611, MD 29 Jun 1957</b> DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Waldfheim</b>		22b. DATE THEREOF <b>June 30 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Waldfheim</b>		22d. LOCATION (City, town, or county) <b>Chicago Ill</b>		(State) <b>Ill</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sal Lerner</b>		ADDRESS <b>W. North Ave Kew 1124-26</b>		24a. REC'D BY REGISTRAR <b>1 1957 J. M. Saylor</b>		24b. REGISTRAR'S SIGNATURE			

WISCONSIN STATE DEPARTMENT OF HEALTH - SEALINONE 18

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 1 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5910

## CERTIFICATE OF DEATH

05887

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY <i>a a</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumbersone</i>		c. LENGTH OF STAY IN 1b <i>1 MONTH</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>00</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Edlesville</i>	
d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>ROBERT</i>	Last <i>LEATHERBURY</i>
4. DATE OF DEATH	Month <i>Oct</i>	Day <i>21</i>	Year <i>57</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 23 1874</i>
9. AGE (In years lost birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. IF UNDER 24 HRS. <i>Hours Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pilot</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Freight Boots</i>	
10c. BIRTHPLACE (State or foreign country) <i>Shadyside Md.</i>		11. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>WM Thomas Leatherbury</i>		14. MOTHER'S MAIDEN NAME <i>ELLEN JANE SIMMONS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>Robert E Leatherbury, Edlesville Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial failure</i>			
DUE TO <i>5020</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>chronic emphysema</i>			
DUE TO <i>acute bronchitis</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Galesville</i> (County) <i>Howard</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>June 10</i> , 19 <i>56</i> to <i>June 20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>June 19</i> , 19 <i>57</i> , and that death occurred at <i>5 a.m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Galesville, Md.</i> DATE SIGNED <i>6-22-57</i>			
ACTUAL SIGNATURE <i>Emily H. Wilson</i>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/23/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Quaker</i>		22d. LOCATION (City, town, or county) <i>Galesville</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burnard Hardisty</i>		ADDRESS <i>Galesville Md.</i>	
24a. REC'D BY REGISTRAR <i>J. J. - v. Green</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. - v. Green</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FBI LABORATORY  
U. S. DEPARTMENT OF JUSTICE  
JUN 27 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05888

5911

## CERTIFICATE OF DEATH

Reg. Dist. No.

78

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6mos.13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount Heights</b>		d. STREET ADDRESS <b>1011 61st Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ruth</b>		First	Middle	Last	4. DATE OF DEATH <b>Lee</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/23/94</b>	9. AGE (In years from birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>James Bayard</b>				14. MOTHER'S MAIDEN NAME <b>Not given</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Not given Hospital Records</b>		Address <b>State Hospital Crownsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>442 X</b>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		DUE TO <b>Nephrosclerosis with Hypertensive Cardiovascular Disease</b>						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>715X Decubitus ulcers and Anemia</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>11/30</b> , 19 <b>56</b> , to <b>6/10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/5</b> , 19 <b>57</b> , and that death occurred at <b>10:45A</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>		
ACTUAL SIGNATURE <i>Lionel M. Mapp</i>		M.D.				DATE SIGNED <b>6/10/57</b>		
PHYSICIAN'S NAME (Type) <b>Lionel M. Mapp, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/15/57</b>		22b. DATE THEREOF <b>6/15/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lincoln Mem. Cem. Jr. Geo. Co., Md.</b>		22d. LOCATION (City, town, or county) <b>JUN 14 1957</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.S. Washington &amp; Sons</i>		ADDRESS <b>467 N St. N.W. Wash. D.C.</b>		24a. RECD BY REGISTRAR <b>JUN 14 1957</b>		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BUREAU A. S.

UN 14 1957

REGGAEVETO

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

VS. ATIME(3)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
a.a. MARYLAND		Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turkey Pt.		b. COUNTY			
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS			
10. Annapolis 123 Madison Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle		
Mary		Elizabeth Levy			
4. DATE OF DEATH		Month	Day		
6 - 19		Year	1952		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Female		White	July 10 1876		
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.		
		88 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		
House wife		Own Home	Maryland		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James Newton Wells		Susan E. Crandall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
			J. Allan Levy Turkey Pt Edgewater Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)					
434.3 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Due to Cancer Disease					
(c) Sudden					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>B. L. Harroff</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-31-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff	22d. LOCATION (City, town, or county) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylorson Annapolis Md		ADDRESS	24a. REC'D BY REGISTRAR DATE 6/24/57	24b. REGISTRAR'S SIGNATURE J. Allan Levy	

BUREAU X

JUN 24 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05890

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Margaret's</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Annapolis</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt Box 94 Annapolis</b>				d. STREET ADDRESS <b>Rt 2 Box 94</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>LINK</b>	Last	4. DATE OF DEATH	Month <b>JUNE</b>	Day <b>6,</b>	Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1886</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Baker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>August Link</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT <b>219-12-58914 Mr Melvin Link- Nephew</b>		Address <b>2200 Eagle St. Baltimore</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Carcinoma of the lungs		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>					
163 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO  (b) With Generalized Metastasis							
DUE TO  (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Glen Burnie</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>May 1st, 1957</b> , to <b>June 6th, 1957</b> , that I last saw the deceased alive on <b>June 1st, 1957</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <b>Glen Burnie, Md.</b>					DATE SIGNED <b>6/8/57</b>		
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>			M.D. <b>Glen Burnie, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or county) <b>Glen Burnie, Md.</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>			ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>J. French</b>		24b. REGISTRAR'S SIGNATURE <b>J. French</b>			
					DATE <b>JUN 11 1957</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the funeral director.

VS A15 (4)  
 15M 9/55

## CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
DEPARTMENT OF HEALTH STATE OF CALIFORNIA SACRAMENTO				
JUN 11 1957				
BUREAU V. A.				
RECEIVED				

## INSTRUCTIONS

**TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05891

## CERTIFICATE OF DEATH

Reg. Dist. No. 34

5914

## 1. PLACE OF DEATH

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Glen Burnie

LENGTH OF STAY  
(in this place)

10 yrs.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

508 Delmar Ave SE

3. NAME OF  
DECEASED  
(Type or Print)

(First) Clara (Middle) Jane

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md.

COUNTY AA

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Glen Burnie

STREET  
ADDRESS

508 Delmar Ave SE

## 5. SEX

F

6. COLOR OR  
RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Widow

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Housewife

10b. KIND OF BUSINESS  
OR INDUSTRY

Own Home

## 11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

## 13. FATHER'S NAME

Alfred Morris

## 14. MOTHER'S MAIDEN NAME

Matilda Moore

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

no

none

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Mrs Edith Long, same as 2

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 157X IMMEDIATE CAUSE

(A)

DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO  
(C)

## 18. MEDICAL CERTIFICATION

Cerebrovascular Disease

INTERVAL BETWEEN  
ONSET AND DEATHII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M.

While  Not while at work  at work 

## 21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE, 1954, to JUNE, 1957, that I last saw the deceased alive on 6-17, 1957, and that death occurred at 12N.M., from the causes and on the date stated above.

SIGNATURE

John McDonald MD

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, Cremation,  
Removal (Specify)

Burial

## DATE THEREOF

6/21/57

## NAME OF CEMETERY OR CREMATORIUM

Cedar Hill

## LOCATION (City, town, or county)

(State)

Baltimore 25, Md

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

Z. J. Dellos

## 25. FUNERAL DIRECTOR'S SIGNATURE

James G. Kirkley ADDRESS, Md  
Hopping & Kirkley, Glen Burnie

DATE JUN 20 1957

RECEIVED - DEPARTMENT OF DEFENSE - CALIFORNIA

CERTIFICATE OF DEATH

RECEIVED

RECEIVED - DEPARTMENT OF DEFENSE - CALIFORNIA

BUREAU V.

JUN 20 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5915

Item 7: G 217 6/15/52

## CERTIFICATE OF DEATH

05892  
25

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Anne Arundel Co. MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural — Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1115 E. Audrey Ave.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Plummer Gordon Lowman			
4. DATE OF DEATH		Month	Day
June 18		1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH
M	W		Jan. 13, 1888
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
69 yrs.		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Carpenter		Self Emp	Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Plummer Lowman		Eliza Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No			Glen Lowman 1115 E. Audrey Ave
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days.	
332X Cerebral Thromboses			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Cerebral Arteriosclerosis		5-6 years	
DUE TO			
(c) Arteriosclerosis, generalized		5-6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
450.0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, 19, to JUNE 18, 1952, that I last saw the deceased alive on JUNE 18, 1952, and that death occurred at 3:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Benjamin Berdann		DATE SIGNED	
PHYSICIAN'S NAME (Type) BENJAMIN BERDANN		M.D. 5010 A Little Guy	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial June 21, 1952		22c. NAME OF CEMETERY OR CREMATORIAL	
Glen Haven Mem Park		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
George Jones 4001 Ritchie Hwy		24a. REC'D BY REGISTRAR DATE JUN 20 1952	
		24b. REGISTRAR'S SIGNATURE Ida Wilson	

DEPARTMENT OF HEALTH - 501 TOWER

CERTIFICATE OF DEATH

REGISTRATION

NUMBER OF DEATH

NAME OF DEATH

NAME OF MARRIED

BUREAU V. S.

JUN 21 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5859

## CERTIFICATE OF DEATH

05893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	b. COUNTY <i>A.A.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	d. STREET ADDRESS <i>1921 Bay Ridge Ave</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>921 Bay Ridge Ave</i>	d. STREET ADDRESS <i>1921 Bay Ridge Ave</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>Samuel</i>	Middle <i>Tilden</i>	Last <i>MacCubbin</i>	4. DATE OF DEATH Month <i>June</i>	Day <i>25</i>	Year <i>1957</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23 - 1905</i>	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. MIN.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Instructor Auto Driver</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Instructor</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Samuel J. Mac Cubbin</i>			14. MOTHER'S MAIDEN NAME <i>Mary Moore</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <i>Hazel Welsh Mac Cubbin</i>	Address <i>2</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto coronary occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>420.1</i> (c)									INTERVAL BETWEEN ONSET AND DEATH <i>unconscious</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>68 Franklin St.</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md</i>	(State) <i>Md</i>		
21. I certify that I attended the deceased from <i>May</i> , 1952, to <i>June 25, 1952</i> , that I last saw the deceased alive on <i>6/20</i> , 1952, and that death occurred at <i>1A</i> M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>John L. Braden</i>	ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>						DATE SIGNED <i>6/28/57</i>			
PHYSICIAN'S NAME (Type) <i>John W. Taylor Sons</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						22b. DATE THEREOF <i>June 28-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Towson Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>	ADDRESS <i>Annapolis Md</i>						24a. REC'D BY REGISTRAR <i>6/28/57</i>	24b. REGISTRAR'S SIGNATURE <i>J. W. Taylor</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5916

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05894  
22

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey		c. LENGTH OF STAY IN lb Few seconds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 4801 Sargeant Street, N.E.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore-Washington Expressway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sister Adelard McAuliffe, O.S.B.		First	Middle	Last	4. DATE OF DEATH June 3rd,	Month	Day	Year 1957
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 60 yrs.	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East Grand Forks, Minn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull						INTERVAL BETWEEN ONSET AND DEATH Sudden		
823X Candians, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car skidded off the highway and turned over.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9.35 A.M. 6/3/57 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route US #8		20f. (City or town) Dorsey, A.A. Md.		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/3/57				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/5/57		22b. DATE THEREOF ADDRESS work.. D.C.		22c. NAME OF CEMETERY OR CREMATORIUM O.S.B. Motherhous Cemetery Duluth,		22d. LOCATION (City, town, or county) Minn.		
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. 314 Pa. Ave., S.E.				24a. REC'D BY REGISTRAR IN 6 1957		24b. REGISTRAR'S SIGNATURE Clarice Hadley		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU X. L

JUN 6 1957

RECEIVED

Memo from the desk of:

Jim Ryan

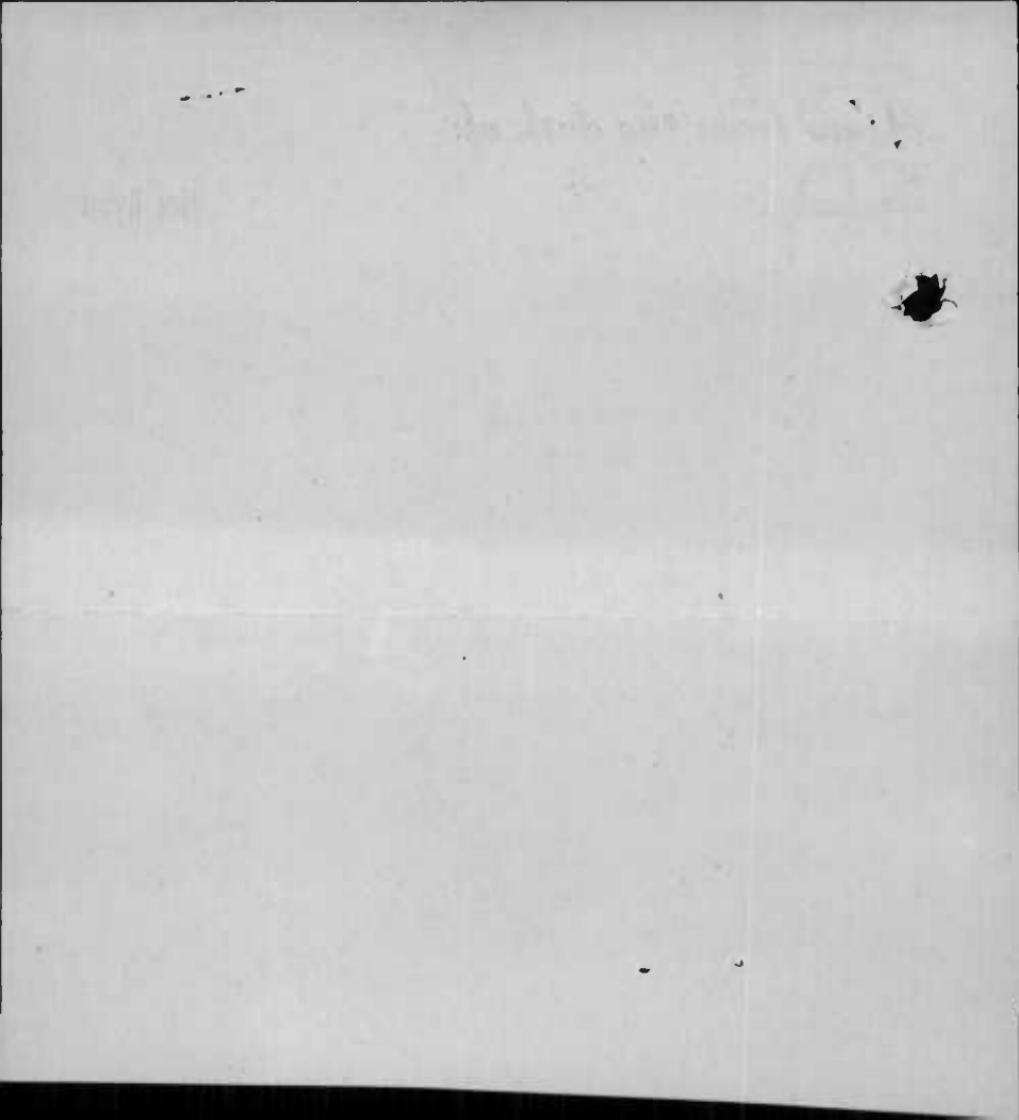
Gentlemen,

We will forward complete information when possible.

None available in this location.

Sincerely,

Jim Ryan, Jr.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5917 Item 8 Film G218 7-18-57 et  
CERTIFICATE OF DEATH

058958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 7mos. 24days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22122			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 514 Delaware Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle McBride		4. DATE OF DEATH Month 6 Day 13 Year 1957					
5. SEX Male Negro		6. COLOR OR RACE Widowed <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1910 Not given 9. AGE (In years lost birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given		10b. KIND OF BUSINESS OR INDUSTRY Not given		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Unk.		16. SOCIAL SECURITY NO. 220-48-9764		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right cardiac failure				INTERVAL BETWEEN ONSET AND DEATH			
026X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C. N. S. Syphilis							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/20/56, 19, to 6/13, 1957, that I last saw the deceased alive on 6/13, 1957, and that death occurred at 10 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ludwig Benedict</i> M.D.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/14/57					
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 17, 57					
22b. DATE THEREOF June 17, 57		22c. NAME OF CEMETERY OR CREMATORIAL Dear Island Cem		22d. LOCATION (City, town, or county) (State) Dear Island Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Booker McWest		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 17 1957		24b. REGISTRAR'S SIGNATURE J. M. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in event within 72 hours after death.

87 згомотнені відповіді до підручника з англійської мови

BUREAU V. S.

1957 JUN 17

REGELIV EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5918 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05896  
*25*

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, if applicable, or removal.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>A.A.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. LENGTH OF STAY IN 1b <b>10 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		d. STREET ADDRESS <b>50 16 Pebble Drive, Lukes Trailer Camp</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pond, branch of Patapsco River</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Stanley Leon McCauley</b>		First	Middle	Last	4. DATE OF DEATH <b>June 19th</b>	Month	Day	Year <b>19 57</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>6/1/47</b>	9. AGE (in years last birthday) <b>10 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pupil</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mill Creek, West Virginia.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Olan Stanley McCauley</b>				14. MOTHER'S MAIDEN NAME <b>Nettie McCauley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Olan McCauley, Father.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Drowning</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Branch of Potapsco River, Brooklyn, A.A.</b>						
20c. TIME OF INJURY Hour <b>6.30</b>		Month, Day, Year <b>a. m. 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Branch of Potapsco River, Brooklyn, A.A.</b>		20f. (City or town) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		DATE SIGNED <b>6/15/57</b>						
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-17-57</b>		22b. DATE THEREOF <b>6-17-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>See Cleary Funeral Home</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 17 1957</b>		24b. REGISTRAR'S SIGNATURE <i>John Hutton</i>		

BUREAU V. S.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5860

## CERTIFICATE OF DEATH

05897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A. Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>A. A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>32 Bloomsbury Sq.</b>		d. STREET ADDRESS <b>32 Bloomsbury</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>NELLIE</b>	Middle <b>E</b>	Last <b>MEEKINS</b>	4. DATE OF DEATH <b>7/21/1957</b>	Month <b>7</b>	Day <b>21</b>	Year <b>1957</b>
5. SEX <b>f</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-2-1884</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN H. COLE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE C. AUSTIN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>William W. MEEKINS #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. } (b) <b>Heart Block</b> DUE TO (c) <b>Congenital heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>About 36 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 433.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 21, 1957</b> , to <b>June 21, 1957</b> , that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>2 pm</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>40 Franklin St, Annapolis, Md.</b>							
DATE SIGNED <b>J. Oliver Purvis</b>							
ACTUAL SIGNATURE <b>J. OLIVER PURVIS</b>		PHYSICIAN'S NAME (Type) <b>J. OLIVER PURVIS</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-23-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>HILLCREST</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		ADDRESS <b>Annapolis, MD.</b>		24a. REC'D BY REGISTRAR <b>6/24/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. Oliver Purvis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

WISCONSIN STATE DEPARTMENT OF HEALTH - CALUMETTE

7220 CERTIFICATE OF DEATH

NAME

DEATH DATE

AGE AT DEATH

SEX

MARITAL STATUS

EDUCATION

RELIGION

EMPLOYMENT

RESIDENCE

DEATH PLACE

CAUSE OF DEATH

TIME OF DEATH

DEATH NUMBER

DEATH DATE

RECEIVED  
BUREAU V. S.

JUN 25 1957

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05898 <i>ny</i>
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach</b>					c. LENGTH OF STAY IN lb <b>2 hrs.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stoney Creek</b>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
f. STREET ADDRESS <b>2460 Nevada St. (2460 Nevada St.)</b>					g. DATE OF DEATH <b>June 23rd.</b>					
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
<b>Edward Barnes Miller</b>					<b>June 23rd.</b>			<b>1957</b>		
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/9/42</b>	9. AGE (in years by birthday) <b>14</b>	IF UNDER 1 YEAR yrs. <b>7</b>	IF UNDER 24 HRS. Months <b>7</b> Days <b>14</b> Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attending School</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Harry M. Miller</b>					14. MOTHER'S MAIDEN NAME <b>Gertrude Dorothy Ferber</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Harry M. Miller, (Father)</b>		Address <b>2460 Nevada Street, Westport</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Browning</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowning (could not swimm)</b>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4.30</b> p.m. <b>6/23/57</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Stoney Creek</b>		20f. (City or town) (County) (State) <b>Orchard Beach A.A. Md.</b>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 24th. 1957.										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-27-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East North Ave. Balto: Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Ruth, Inc. - 1735 Harford Avenue Balto: Md.</b>					24a. END BY REGISTRAR DATE <b>JUN 26 1957</b>					
					24b. REGISTRAR'S SIGNATURE <i>L.J. Kelly</i>					

RECEIVED

BUREAU V. A.

JUN 26 1957

Mr. Edward K. Gandy, Esq., Attorney

RECEIVED - JUN 26 1957 - 1957 RELEASE UNDER E.O. 14176

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached from the original certificate and given to the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5861 CERTIFICATE OF DEATH

05899

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>906 Ridgeway Ave.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Thelma</b>		First	Middle <b>F.</b>	Lost	4. DATE OF DEATH <b>June 17, 1957</b>	Month <b>June</b>	Day <b>17</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 27, 1902</b>	9. AGE (In years lost birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months <b>55</b>	IF UNDER 24 HRS. Days <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James L. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Morrisberger</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr Eugene L. O'Neale - Husband - same as # 2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Congestive Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>		
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>260x</b>						
		(b) <b>Arteriosclerosis c.v.d</b>				<b>yr.</b>		
		DUE TO (c) <b>Diabetes M.</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hangover, left foot &amp; leg, amputated</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. g. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Elkton</b> (County) <b>Md.</b> (State)		
21. I certify that I attended the deceased from <b>12-22-1952</b> to <b>6-17-1957</b> , that I last saw the deceased alive on <b>6-12-1957</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Frank M. Shipley</b>		ADDRESS (Street, city or town, state) <b>63 College Ave. Annapolis, Md.</b>				DATE SIGNED <b>6-19-57</b>		
PHYSICIAN'S NAME (Type) <b>Frank Shipley</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) <b>Elkton, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Lynch</b>		

WISCONSIN STATE DEVELOPMENT DEPARTMENT

CERTIFICATE OF DEATH

BUREAU X. S.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5862

## CERTIFICATE OF DEATH

Reg. Dist. No.

0590021

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.C.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>vs Annapolis</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>C. A. General Hosp.</i>		e. STREET ADDRESS <i>1800 St. Washington</i>					
3. NAME OF DECEASED (Type or print) <i>Carrie C. Keeler</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>18</i> Year <i>1957</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <i>Female</i>		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12-3-1884</i>	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nelson W. Gowan</i>		14. MOTHER'S MAIDEN NAME <i>Mary M. Crowley</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>443X</i>		17. INFORMANT <i>Siby Brown-Anna. And.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-Pneumonia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arterio-venous fistula</i>		(b) <i>Cerebral Hemorrhage</i>					
DUE TO <i>Arterio-venous fistula</i>		DUE TO <i>Arterio-venous fistula</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterio-venous fistula</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/20/1957</i> to <i>6/18/1957</i> , that I last saw the deceased alive on <i>6/18/57</i> , and that death occurred at <i>1150</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>M.D. 10-ohay st Annapolis, Md. 6/19/57</i>	
ACTUAL SIGNATURE <i>R. Richardson</i>						DATE/SIGNED <i>6/19/57</i>	
PHYSICIAN'S NAME (Type) <i>William Reese Jr - Anna. Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-23-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Jr - Anna. Md.</i>		ADDRESS <i>1150-ohay st Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>J. Finch</i>		24b. REGISTRAR'S SIGNATURE <i>J. Finch</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - STATE GOVERNMENT OF HAWAII - CALIFORNIA

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5863

## CERTIFICATE OF DEATH

05901

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE					
<i>Anne Arundel</i> MARYLAND		Maryland A.A.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Annapolis</i>		<i>Annapolis</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) o. INSTITUTION		d. STREET ADDRESS					
<i>A.A. General Hosp.</i>		<i>125 Monument St.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle				
<i>L. L. E. Vicker</i>							
4. DATE OF DEATH		Month	Day				
		8	16				
		Year	1957				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at death) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
<i>Female</i>		<i>Col</i>		<i>3-14-1884</i>	<i>73</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Housewife</i>				<i>Annapolis, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
<i>Charles Davis</i>		<i>Mary Lee</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or None) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
<i>No</i>				<i>Mary S. Harris - Annapolis, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Cerebral thrombosis</i>					
332X		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)					
{		DUE TO					
cause (a), stating the under- lying cause last.		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-11-57</i> , to <i>4-16-57</i> , that I last saw the deceased alive on <i>3-16-57</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE		<i>C. J. Allen</i>					
PHYSICIAN'S NAME (Type)		<i>C. J. Allen</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6-19-57</i>		<i>Brewer Hill</i>		<i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR DATE					
<i>William Beese, Jr. - Annapolis, Md.</i>		<i>J. J. French</i>					
ADDRESS		24b. REGISTRAR'S SIGNATURE					

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

JUN 21 1957

BUREAU V. S.  
RECEIVED  
JUN 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5864

## **CERTIFICATE OF DEATH**

05902

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		South River Park		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		18 Edgewater P.O. Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
2. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month	Day	Year
Male White		Allen Roy Peake		8. Date of birth		6 -	7	19 57
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. Age		IF UNDER 1 YEAR IF UNDER 24 HRS.
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. Date of birth		10 - 6 - 1888	68	Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Ret Plumber		Plumber		Md		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
Millard E. Peake		Emma Cole		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address
				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 4 mos.
18IX		DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) carcinoma of bladder		5 yrs.
DUE TO				{		(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from Jan. 19 50 to June 7, 19 57, that I last saw the deceased alive on June 7, 19 57, and that death occurred at 2:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D. Amos Garrett Blvd. DATE SIGNED 6/10/57								
PHYSICIAN'S NAME (Type)		S. Borssuck, M.D.		Annapolis, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)
Burial		6-10-57		Quaker Burial Grounds		Westover		Md
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REC'D BY STAMPS SIGNATURE		
John M. Taylor Sons		Annapolis, Md.		DATE 6/10/57				

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH

REGISTRATION

NUMBER

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

RELATIONSHIP

TO DECEASED

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

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NAME

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PHONE NUMBER

RELATIONSHIP

BUREAU V. S.

JUN 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5865

## CERTIFICATE OF DEATH

05903

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Anne Arundel Maryland</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		<i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>O.A. General Hosp.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Queen</i>	Last <i>6</i>
4. DATE OF DEATH	Month <i>8</i>	Day <i>24</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-1-1884</i>
9. AGE (In years last birthday) yrs. <i>73</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Henry Queen</i>	14. MOTHER'S MAIDEN NAME <i>Sallie Dugge</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Shelton, Queen - Waterbury, Md.</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombous R middle cerebral artery</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
491X Terminal cerebral purpura			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/18</i> , 19 <i>57</i> , to <i>6/24</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/23</i> , 19 <i>57</i> , and that death occurred at <i>42A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John L. Holleman</i>	M.D.		ADDRESS (Street, city or town, state) <i>68 Franklin St. Annapolis, Md.</i>
PHYSICIAN'S NAME (Type)	DATE SIGNED <i>6/25/57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-26-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Johns Cemetery</i>	22d. LOCATION (City, town, or county) <i>Waterbury, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Geese, Clifton, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>115 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Lynch</i>

## WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF DISEASES

## CERTIFICATE OF DEATH

REGISTRATION

BUREAU U.S.

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5866 CERTIFICATE OF DEATH

Reg. Dist. No.

05904

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>aa</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>10</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		d. STREET ADDRESS <i>1112 Eastport Terrace</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. C. General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Nellie L.</i>	Middle <i>Racey</i>	Last <i>Racey</i>	4. DATE OF DEATH <i>6 - 25 1957</i>	Month <i>6</i>	Day <i>25</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>3-25-1908</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months <i>52</i>	IF UNDER 24 HRS. Days <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Edwin S. Hager</i>				14. MOTHER'S MAIDEN NAME <i>Effie M. Melburn</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Leroy P. Hager</i>		Address <i>5200 9th St. S.E. Washington 27 D.C.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia</i> : DUE TO 442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arteriosclerotic cardio-vascular</i> DUE TO renal disease c ; hypertension (c)								
INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 576 X <i>localized peritonitis (cause not determined)</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>6/18/57</i> , 19 <i>6/25/57</i> , 19, that I last saw the deceased alive on <i>6/25/57</i> , 19, and that death occurred at <i>11:30A</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Amos Garrett Blvd.</i> DATE SIGNED <i>6/28/57</i>								
ACTUAL SIGNATURE <i>S. Borssuck</i> M.D.								
PHYSICIAN'S NAME (Type) <i>S. Borssuck, M.D.</i> Annapolis, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-28-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, county) <i>Annapolis Md.</i> State <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6/28/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. W. Taylor</i>		

## CERTIFICATE OF DEATH

RECEIVED  
BUREAU N.Y.  
JUL 3 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05905  
25

5920

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Hanover Crumel Lee Maryland</i>		a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY <i>Brooklawn Park</i>	
<i>Brooklawn Park</i>	<i>6 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>58 Brooklawn Taylor</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS <i>226 Aden Road</i>		
<i>226 Aden Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Katie</i>	Middle <i>Patricia</i>	Last <i>Patton</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>13</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>April 30, 1897</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 MRS. Days <i>0</i>	12. IF UNDER 24 MRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Housework at home</i>		<i>Baltimore, Md.</i>	<i>U.S.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Jacob Strupp</i>	<i>Melia cigar</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
			<i>Mrs Joseph Cappello 629 Aldershot Rd.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>420.1</i>			
DUE TO <i>Coronary thrombosis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO <i>Coronary insufficiency</i>			
(c)			
INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>o. m.</i> Month <i>June</i> Day <i>19</i> Year <i>1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-8</i> , 19 <i>53</i> , to <i>6-13</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6-13</i> , 19 <i>57</i> , and that death occurred at <i>8P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eugene Schmitz</i>		ADDRESS (Street, city or town, state) <i>3904 S. Hanover St.</i> DATE SIGNED <i>17 Jun 1957</i>	
PHYSICIAN'S NAME (Type) <i>Eugene Schmitz, M.D.</i>			
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i> <i>1957</i>		22b. DATE OF REMOVAL <i>1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore City</i>		22d. LOCATION (City, town, or county) (State) <i>8 North Ave.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Holloman</i>		24a. REC'D BY REGISTRAR DATE <i>17 Jun 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Ada Hartman</i>	

## MISSOURI STATE DEPARTMENT OF HEALTH - DIVISIONS

## CERTIFICATE OF DEATH

MO 100-1000

DECEASED'S NAME JOHN D. HARRIS	SEX M	AGE 65	CAUSE OF DEATH COPD
ADDRESS 123 FAIRFIELD DR.	STATE MO	CITY KANSAS CITY	ZIP 64110
NAME AND ADDRESS OF PERSON REPORTING DR. JAMES H. HARRIS 123 FAIRFIELD DR. KANSAS CITY, MO 64110			
NAME AND ADDRESS OF PERSON RECEIVING COPIES DR. JAMES H. HARRIS 123 FAIRFIELD DR. KANSAS CITY, MO 64110			
DATE OF DEATH JUN 17 1957			
RECEIVED BUREAU V. S.			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5867

## CERTIFICATE OF DEATH

05906

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL and give nearest town Annapolis, Md.</b>		c. LENGTH OF STAY IN 1b		b. COUNTY <b>Maryland</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hosp. Annapolis, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. STREET ADDRESS <b>1010 Jackson Street</b>											
3. NAME OF DECEASED (Type or print) <b>John</b>		First	Middle	Last	4. DATE OF DEATH <b>JUNE 5 1957</b>	Month	Day	Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-83</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LT USN RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>					
13. FATHER'S NAME <b>Emery (n) RAYHART</b>					14. MOTHER'S MAIDEN NAME <b>Helen (n) BABOT</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1908-1937</b>		17. INFORMANT <b>U.S. Naval Hospital, Annapolis, Md.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>161X</b> DUE TO <b>Carcinoma, squamous - cell, metastatic (Primary site larynx)</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  } (b) DUE TO  (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Extreme Cachexia</b>											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Annapolis</b>		(County) <b>Maryland</b>		(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>4 June 1957</b> , to <b>5 June 1957</b> , that I last saw the deceased alive on <b>5 June 1957</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Annapolis, Md.</b>											
DATE SIGNED <b>Luis A. Morales</b>											
ACTUAL SIGNATURE <b>Luis A. Morales</b>											
PHYSICIAN'S NAME (Type) <b>Luis A. MORALES LCDR MC USNR</b>											
22a. BURIAL, CREMATION, REMOVAL <b>Burial</b>											
22b. DATE THEREOF <b>June 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>National Cemetery</b>				22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>					
23. FUNERAL DIRECTOR SIGNATURE <b>HOPPING FUNERAL HOME</b>											
ADDRESS <b>Annapolis, Maryland</b>											
24a. REC'D BY REGISTRAR DATE <b>1957</b>											
24b. REGISTRAR'S SIGNATURE <b>J. M. J. French</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V.

JUN 7 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 6 Film 6217 6-20-57 et  
5868

## CERTIFICATE OF DEATH

05907  
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>46 Southgate Ave.</b>		d. STREET ADDRESS <b>46 Southgate Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HARRY</b>		First	Middle <b>A</b>	Last <b>REICHEL</b>	4. DATE OF DEATH <b>JUNE 19,</b>	Month	Day <b>19</b>	Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug 6, 1902 1901</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>5</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Hyman Reichel</b>		14. MOTHER'S MAIDEN NAME <b>Lena R. Reichel</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Lena Reichel -- Wife- same as # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Coronary Thrombosis</b>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b)		DUE TO		<b>Artioelectric Cardio Vascular Disease?</b>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4221</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>31 Southgate Ave.</b>		20f. (City or town) <b>Annapolis</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>May</b> , 19 <b>56</b> , to <b>June 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 5</b> , 19 <b>57</b> , and that death occurred at <b>31 Southgate Ave.</b> , Annapolis, Md., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>31 Southgate Ave.</b>		DATE SIGNED <b>Maurice F. Klawans</b>	
ACTUAL SIGNATURE <b>Maurice F. Klawans</b>									
PHYSICIAN'S NAME (Type) <b>Maurice F. Klawans</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-20-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Kneseth Israel Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John J. French</b>			

DEPARTMENT OF STATE - DIVISION OF RECORDS - WASHINGTON, D.C.

CERTIFICATE OF DEATH

BUREAU Y. A.  
RECEIVED  
JUN 20 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5921

## CERTIFICATE OF DEATH

05908  
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		<i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
		MARYLAND		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>Eastport, Md</i>		<i>Summer</i>		<i>Eastport, Md</i> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<i>III Eastern Ave</i>		<i>6 1/2 Eastern Ave.</i>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
<i>Kennie M. Robinson</i>					<i>June 28</i>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
<i>Female</i>		<i>White</i>		<i>1886</i>	<i>71</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Home</i>		<i>Wisconsin</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
<i>Jacob Faarby</i>		<i>Hannah Adel</i>		<i>Dr Aaron Robinson - 1817 Eastern Pl.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
						<i>Coronary Disease</i>	
420.1		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH days	
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 18</i> , 19 <i>57</i> to <i>June 18</i> , 19 <i>57</i> that I last saw the deceased alive on <i>June 18</i> , 19 <i>57</i> and that death occurred at <i>6 1/2 Eastern Ave.</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. L. in b.s.c.H.</i> PHYSICIAN'S NAME (Type)		ADDRESS (Street, City or Town, state) <i>Baltimore, Md.</i> DATE SIGNED <i>6/21/57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL <i>Israel Israel</i>		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>June 30/57</i>				<i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
		<i>117th Ave</i>				<i>John J. French</i>	
VS A1S (4) 1SM 9/SS		Sol Levenson Bros. Inc. 434-26		DATE 1		1957	

## CERTIFICATE OF DEATH

BUREAU V. S.

JUL 1 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5922

## CERTIFICATE OF DEATH

Reg. Dist. No.

05909  
78

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>5 yrs 7 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Susie</i>	Middle <i></i>	Last <i>Robinson</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>9</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Not given</i>	8. DATE OF BIRTH <i>Not given</i>
9. AGE (In years last birthday) <i>85</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Not given</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Ben Powell</i>	
14. MOTHER'S MAIDEN NAME <i>Julia Fipps</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1</i>		Address <i>Crownsville State Hospital Crownsville, Md.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
DUE TO <i></i>			
DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cancer of cervix with metastasis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 23, 1951</i> , to <i>June 9, 1957</i> , that I last saw the deceased alive on <i>June 9, 1957</i> , and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ludwig Benedict</i>		ADDRESS (Street, city or town, state) <i>Crownsville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Ludwig Benedict, M. D.</i>		DATE SIGNED <i>6/10/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removed</i>	22b. DATE THEREOF <i>6-12-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>21st of May</i>	22d. LOCATION (City, town or county) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Gleeson - Anna, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>JUN 17 1957</i>	24b. REGISTRAR'S SIGNATURE <i>A. M. Joyce</i>

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISIONS 16

CERTIFICATE OF DEATH

BUREAU V.  
RECEIVED  
JUN 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05910

5923

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>A.A. County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>North Linthicum</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>21 Hampton Road</b>		e. STREET ADDRESS <b>21 Hampton Road</b>	
3. NAME OF DECEASED (Type or print) <b>Charles J.H. Roos, Sr.,</b>		4. DATE OF DEATH <b>Roos, Sr.,</b>	Month <b>June</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 26, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher (Ret'd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Charles J.H. Roos, Jr., 29 Hampton Rd., Linthicum</b>	
17. INFORMANT <b>Charles J.H. Roos, Jr., 29 Hampton Rd., Linthicum</b>		Address <b>North</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>432.1</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>50</b> to <b>June</b> , 19 <b>57</b> that I last saw the deceased alive on <b>June 1, 1957</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Paul Schonfeld</b> M.D. <b>2301 Annapolis Rd</b> DATE SIGNED <b>6/18/57</b>			
PHYSICIAN'S NAME (Type) <b>Paul Schonfeld</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, & county) <b>Ridgely Highway</b> (State) <b>Ridgely Highway</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>1217 St. Paul Street</b>	
24a. REC'D BY REGISTRAR <b>1957</b>		24b. REGISTRAR'S SIGNATURE <b>John A. Schonfeld</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION  
CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 05911 21	
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b> <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cape St. Claire, P.O. Annapolis.</b>					c. LENGTH OF STAY IN 1b <b>15 minutes.</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Magothy River</b>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 30 30014						
3. NAME OF -DECEASED (Type or print) <b>William Edward Ross</b>					First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7/3/40</b>	9. AGE (in years last birthday) <b>16 yrs.</b>	10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper in a grocery store.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Ross</b>					14. MOTHER'S MAIDEN NAME <b>Eileen Schultz</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small> <b>No</b>		16. SOCIAL SECURITY NO. <small>(If yes, give war or dates of service)</small>		17. INFORMANT <b>Mrs. William Ross (mother)</b>		Address <b>1449 HULL ST.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning</b> <b>850X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
20a. EXTERNAL CAUSE WAS PRIMARILY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped in the water from a rowboat and could not swim.</b>									
20c. TIME OF INJURY <b>2:15 P.M. 6/2/57</b>		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Magothy River</b>		20f. (City or town) <b>Cape ST. CLAIRE, A.A. Md.</b>		(County) (b) State	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>Gustave H. Faubert, M.D.</b>											
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>										DATE SIGNED <b>6/2/57</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>GLENN HAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) <b>ANNE ARUNDEL</b>		(State) <b>M.D.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Faubert</b>		ADDRESS <b>1501 E. Fort Ave</b>		24a. REC'D BY REGISTRAR <b>6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Tom J. Lynch</b>					

BUREAU V. S.

JUN 6 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05912  
M

5925

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena, Md.</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 2, Md. 3401-4 ✓</b>	
3. NAME OF DECEASED (Type or print) <b>Grace</b>		First <b>Marie</b>	Middle <b>Ruppel</b>
4. DATE OF DEATH <b>June 5, 1957</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	11. BIRTHPLACE (State or foreign country) <b>Winfield, Md.</b>
13. FATHER'S NAME <b>Edward M. Zile</b>		14. MOTHER'S MAIDEN NAME <b>Emma Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-38-7211</b>	17. INFORMANT Address <b>Emma Elseroad, Pasadena, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>liveria (blockage of both ureters)</b> DUE TO <b>154X</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis</b> DUE TO ?			
(c) <b>Carcinoma of the recto-sigmoid</b> DUE TO <b>1½ years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March</b> , 1957, to <b>May 5</b> , 1957, that I last saw the deceased alive on <b>May 5</b> , 1957, and that death occurred at <b>M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Grace G. Jones, Md.</b>	M.D. 900 Reisterstown Rd - 6/7/57		
PHYSICIAN'S NAME (Type) <b>Dr. Grace G. Jones</b>	Baltimore 8- Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville 8, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville 8, Md.</b>	ADDRESS <b>JUN 10 1957</b>	24a. REC'D BY REGISTRAR <b>JUN 10 1957</b>	24b. REGISTRAR'S SIGNATURE <b>L. J. DeLay</b>

WISCONSIN STATE DEPARTMENT OF HEALTH - SAVINOME, 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFIED BY
ADDRESS OF DECEASED						
CITY, STATE, ZIP CODE						
NAME AND ADDRESS OF HOSPITAL OR MEDICAL FACILITY						
NAME AND ADDRESS OF DOCTOR						
NAME AND ADDRESS OF FUNERAL HOME						
NAME AND ADDRESS OF PERSON REPORTING						
DATE RECEIVED						
RECEIVED						

BUREAU V. A.

JUN 10 1957

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5869 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05913

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>A. A.</i>		a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		b. COUNTY <i>A. A.</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. &amp; Gen Hospital</i>		d. STREET ADDRESS <i>W. Washington</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Randolph Russell</i>		First	Middle
Last		4. DATE OF DEATH	Month
5. SEX <i>Male</i>		5. COLOR OR RACE <i>Colored</i>	Day
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. DATE OF BIRTH <i>Sept. 23 1903</i>	Year
7. 7. BIRTHPLACE (State or foreign country) <i>Calvert Co.</i>		9. AGE (In years last birthday) <i>93 yrs.</i>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>City Employee</i>	10c. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Randolph Russell sr.</i>		14. MOTHER'S MAIDEN NAME <i>Mary unknown</i>	Address <i>Arma May Russell, Annapolis</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-05-4748</i>	17. INFORMANT <i>Arma May Russell, Annapolis</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>Several days</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.9</i>		DUE TO <i>Heart disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE <i>Bernard F. Lichardt</i>	
EXAMINER'S NAME (Type) <i>E. Lichardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>6/1/57</i>
22a. (RURAL) CREMATION, REMOVAL (Specify) <i>Funeral</i>	22b. DATE THEREOF <i>June 15/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Brent Hill</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arnold J. Brown Annapolis</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JUN 18 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John J. French</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

287 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MICHIGAN STATE BUREAU OF HIGHWAYS

NAME OF PERSON	DECEASED
AGE	60 years
SEX	Male
CAUSE OF DEATH	Cardiac arrest
TIME OF DEATH	10:00 P.M.
PLACE OF DEATH	Hospital
EXAMINER'S SIGNATURE	
EXAMINER'S TITLE	Medical Examiner
EXAMINER'S ADDRESS	Michigan State Bureau of Highways Lansing, Michigan
EXAMINER'S PHONE NUMBER	517-393-1111

BUREAU V. S

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5926 CERTIFICATE OF DEATH

05914

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hallsville</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Riviera Beach</i>		d. STREET ADDRESS <i>Riviera Beach</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dennis Nursing Home</i>				d. STREET ADDRESS <i>Anne Arundel and Bay Roads</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JOHN</i>		First	Middle <i>FRED</i>	Last <i>SCHMIDT</i>	4. DATE OF DEATH <i>JUNE 11 1957</i>	Month <i>JUNE</i>	Day <i>11</i>	Year <i>1957</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 30-1869</i>	9. AGE (In years lost birthday) yrs. <i>87</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gunner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.U.A.</i>			
13. FATHER'S NAME <i>Euston Schmidt</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Rhinehart</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>47-24-7073</i>		17. INFORMANT <i>Mrs. Sarah C Schmidt</i>		Address <i>Riviera Beach</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		DUE TO <i>Arteriosclerotic Cardio Vasculitis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerosis</i>		(c)				<i>5 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>450.0</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>Riviera Beach</i>		(County) <i>Riviera Beach</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>10/30</i> , 19 <i>56</i> , to <i>6/11</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/11</i> , 19 <i>57</i> , and that death occurred at <i>8:15 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Riviera Beach, Md.</i>		DATE SIGNED <i>6/2/57</i>			
ACTUAL SIGNATURE <i>J. Brady Smith M.D.</i>		PHYSICIAN'S NAME (Type) <i>J. Brady Smith</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Park</i>		22d. LOCATION (City-Town, or County) <i>Baltimore Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 14-1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Park</i>		22d. LOCATION (City-Town, or County) <i>Baltimore Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burgess Funeral Home</i>		ADDRESS <i>3631 Falls Road Baltimore</i>		24a. RECEIVED BY REGISTRAR <i>JUN 14 1957</i>		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 14 195

REGELV E D

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5870

## CERTIFICATE OF DEATH

05915

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Anne Arundel MARYLAND</i>		<i>Maryland A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	d. STREET ADDRESS	
<i>Annapolis</i>	<i>1b</i>	<i>x2 Churchton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General Hosp.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Susie Scott</i>	First	Middle	4. DATE OF DEATH Month Day Year <i>JUNE 17 1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-27-1881</i>
9. AGE (In years lost birthday) yrs. <i>76</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Churchton, Md. U.S.A.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>William Blunt</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Atlee</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Frank Blunt - Churchton, Md.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>INTRACEREBRAL HEMORRHAGE</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>6 DAYS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>241X CHRONIC ASTHMATIC BRONCHITIS</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>MARCH</i> , 19 <i>57</i> , to <i>JUNE 17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>JUNE 17</i> , 19 <i>57</i> , and that death occurred at <i>505</i> M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>John L. H. Leesman</i> M.D. PHYSICIAN'S NAME (Type) <i>John L. H. Leesman</i> ADDRESS (Street, city or town, state) <i>88 FRANKLIN ST.</i> DATE SIGNED <i>6/17/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 6-21-57</i>	22b. DATE THEREOF <i>6-21-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cromwell</i>	22d. LOCATION (City, town, or county) (State) <i>Churchton</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 20 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

JUN 21 1957

# REGGAE VIBE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5871

Items 5,6 FilmG217 7-2-51 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

05917

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
A.A. MARYLAND		MD A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL BALTIMORE	1 day	Harwood Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
H.A. Levine	/		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	BENJAMIN		SIMMS
4. DATE OF DEATH	Month	Day	Year
	JUNE	21	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	(1913) Feb 17 1949
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
44			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Tobacco	Harwood	Address Harwood
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Joseph A Simms	Mirtha E Parker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
NO	218-14-3391	Joseph E. SIMMS JR.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
			241X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b)		Cerebral arrest
	DUE TO		acute Bronchial asthma
	(c)		Purulent Bronchitis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
502.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
Hour a. m. p. m.	Month, Day. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE Emily H. Wilson	M.D.	DATE SIGNED 6-22-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	6/23/57	Chews	Chesapeake, Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Burial Facility Galiville, Md.		6/26/57	60 - 000000

2501 to N.Y.

**REGELVÉD**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05918

5872

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 Southgate Ave.</u>		d. STREET ADDRESS <u>72 Southgate Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u>		First <u>H</u>	Middle <u>SMALL</u>	Last <u></u>	4. DATE OF DEATH <u>June 11</u>	Month <u>11</u>	Doy <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>July 11, 1888</u>	9. AGE (In years lost birthday) <u>68 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thomas Small</u>				14. MOTHER'S MAIDEN NAME <u>Ella Jewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. none		17. INFORMANT <u>William A. Samll- Son - same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>420.0 Atherosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420.0</u>					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>206</u>	(County) (State) <u>Baltimore</u>
21. I certify that I attended the deceased from <u>6-10-</u> , 19 <u>57</u> , to <u>6-11-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-10-1957</u> , and that death occurred at <u>206</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>206 Annapolis, Maryland</u> DATE SIGNED <u>6/13/57</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>James R. Martin</u>		2 Shaw Street		Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-14-57</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Annapolis, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>JUN 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Tom J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

BUREAU OF INVESTIGATION  
DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

BUREAU OF INVESTIGATION

JUN 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5927

## CERTIFICATE OF DEATH

05919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN 1b 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1220 Lewis Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Dallas	Middle Smith	Last 4. DATE OF DEATH Month 6 Day 10 Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1908
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Williams		14. MOTHER'S MAIDEN NAME Alene Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-12-206	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension 447X	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/6, 1957, to 6/10, 1957, that I last saw the deceased alive on 6/8, 1957, and that death occurred at 2:45 a. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. 6/10/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/13/57	22b. DATE THEREOF 6/13/57	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Van Zandt and Baltot		24a. REC'D BY REGISTRAR DATE 6/13/57	24b. REGISTRAR'S SIGNATURE R. M. Jayne

## MARYLAND STATE DEPARTMENT OF HEALTH - SANITATION

## CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	60	MALE	HEART DISEASE
ADDRESS	STREET	CITY	STATE
100 E. BELMONT	APT. 202	BALTIMORE	MARYLAND
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR	NAME AND ADDRESS OF CEMETERY	
DR. JAMES M. COOPER 100 E. BELMONT	COOPER FUNERAL HOME 100 E. BELMONT	WOODLAWN CEMETERY 100 E. BELMONT	
NAME OF PERSON REPORTING	RELATIONSHIP	ADDRESS	
JOHN COOPER	SPOUSE	100 E. BELMONT	
I declare that the above information is true to the best of my knowledge.			
SIGNED: JOHN COOPER			
JUN 12 1957			

BUREAU V. S

JUN 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5928

## CERTIFICATE OF DEATH

05920  
28

Reg. Dist. No.

1		M		I		2		2	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4									
may be retained by the hospital or attending physician.									
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.									
10									
13									
15									
18									
20									
21									
22									
23									
VS A15 (4) 15M 9/55									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>17 yrs. 11 mos. 14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		d. STREET ADDRESS <b>Not given</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>									
3. NAME OF DECEASED (Type or print) <b>Randall</b>		First	Middle	Last	<b>Smith</b>	4. DATE OF DEATH <b>6 5 1957</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1875?</b>	9. AGE (In years last birthday) <b>82? yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. Year <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Not given</b>				14. MOTHER'S MAIDEN NAME <b>Not given</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b>						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Heart Failure							
DUE TO (c)		Senile Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diarrhea of Undetermined Etiology</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>57.1</b>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Crownsville, Md.</b>		20f. (City or town) (County) <b>Crownsville</b> (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>1/22</b> , 19 <b>48</b> , to <b>6/5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/4</b> , 19 <b>57</b> , and that death occurred at <b>6:30 a.m.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ludwig Benedict</i>				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>		DATE SIGNED <b>6/5/57</b>			
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/7/57</b>		22b. DATE THEREOF <b>6/7/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Crownsville State Hospital</b>		22d. LOCATION (City, town, or county) <b>Crownsville</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter W. Meng</i>		ADDRESS <b>Crownsville, Md.</b>		24a. REC'D. BY REGISTRAR DATE <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <i>A. M. Jorgens</i>			

81-382944-2. JAGD-FLUGZEUGSTAT. GNAUER

BUREAU V. S.

2501 IT JUN

REGELVÉD

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05921

5929

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

## 1. PLACE OF DEATH

COUNTY

(Name) *James McDonald*

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)TOWN *Millersville*LENGTH OF STAY  
(in this place)*4 1/2 months*HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS*Saints Nursing Home*

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

(Name) *Maryland*

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET  
ADDRESS*Marely Park Glen Bowie*

(If rural give location)

*115 Holland Road*3. NAME OF  
DECEASED  
(Type or Print)(First) *James*

(Middle)

(Last)

*Snider*4. DATE  
(Month)  
OF  
DEATH(Day)  
6 12(Year)  
19 57

## 5. SEX

*F*6. COLOR OR  
RACE*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)*Widow*

## 8. DATE OF BIRTH

*May 6, 1882*

## 9. AGE last birthday

*75*

yrs.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)*Housework*10b. KIND OF BUSINESS  
OR INDUSTRY*own home*

## 11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF WHAT  
COUNTRY?*U.S.A.*

## 13. FATHER'S NAME

*James Wissar*

## 14. MOTHER'S MAIDEN NAME

*James Crebbi, Glen Bowie, Md.*

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

*No*

## 16. SOCIAL SECURITY NO.

*None*

## 17. INFORMANT &amp; ADDRESS

*James Crebbi, Glen Bowie, Md.*INTERVAL BETWEEN  
ONSET AND DEATH*36 hrs*

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)

DUE TO

*Labor Pneumonia.*

## ANTECEDENT CAUSE(S)

DISEASES OR CONDITIONS, IF ANY,

(B)

GIVING RISE TO THE ABOVE CAUSE

DUE TO

STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.*Diabetes - Hypertension*

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
of INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)  
(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. While at work  Not while at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 19, 1955*, to *June 19, 1957*, that I last saw the deceased alive on *June 11, 1957*, and that death occurred at *10:45 A.M.* from the causes and on the date stated above.

## SIGNATURE

*Charles P. McDonald*

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE *JUN 17 1957**J. M. Jaya**Mc. Gyn C. Fahey Taneytown Md.*

DEPARTMENT OF STATE DEPARTMENT OF HEALTH-EDUCATION

MESSAGE TO DEATH

ALL INFORMATION

ALL INFORMATION

BUREAU V.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5873

U5922

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>Apt. F-5, Perry Circle</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Robert</u>	Middle <u>Hammond</u>	Last <u>Stokes</u>	4. DATE OF DEATH Month June	Day 17	Year 1957
---	------------------------	--------------------------	-----------------------	---	-----------	--------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6-17-57</u>	9. AGE (In years last birthday) yrs. <u>6</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 24 HRS. Days <u>48</u> Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
--	-----------------------------------	--	---

13. FATHER'S NAME <u>Charles Randle Stokes</u>	14. MOTHER'S MAIDEN NAME <u>Patricia Hammond McCarthy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>U. S. Naval Hospital, Annapolis, Md.</u>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____		six hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>6-17</u> , 19 <u>57</u> , to <u>6-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>57</u> , and that death occurred at <u>1148AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francesco De Paola</u>		ADDRESS (Street, city or town, state) <u>N.D.</u>	DATE SIGNED <u>6-17-57</u>

PHYSICIAN'S NAME (Type) <u>Francesco (n) De Paola LT MC USNR</u>	22b. DATE THEREOF <u>6-29-57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Naval Cemetery</u>	22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>	ADDRESS <u>Annapolis, Md.</u>	24a. REC'D BY REGISTRAR- <u>JUN 20 1957</u>	24b. REGISTRAR'S SIGNATURE <u>M. J. Lynch</u>

2051335XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MISSOURI STATE DEPARTMENT OF LABOR - DIVISION 10

## CERTIFICATE OF DEATH

RECEIVED

SEARCHED	INDEXED
SERIALIZED	FILED
JUN 20 1957	
FBI - ST. LOUIS	
ST. LOUIS, MISSOURI	
FEDERAL BUREAU OF INVESTIGATION	
U. S. DEPARTMENT OF JUSTICE	

BUREAU V.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5930

## CERTIFICATE OF DEATH

05923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2mos. 17days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		23X02 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>R. F. D.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Simon</b>		First	Middle	Last	4. DATE OF DEATH <b>Sturgis</b>	Month <b>6</b>	Day <b>12</b>	Year <b>19 57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not given</b>	9. AGE (In years last birthday) <b>29? yrs.</b>	IF UNDER 1 YEAR Months <b>-</b>	Days <b>-</b>	Hours <b>-</b>	IF UNDER 24 HRS. Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Not given</b>		14. MOTHER'S MAIDEN NAME <b>Not given</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Crownsville State Hospital Crownsville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive lung metastasis</b> 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Neurofibrosarcoma left shoulder girdle DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Multiple abscesses incident to above</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>March 26, 19 57</b>		20f. (City or town) <b>6/12</b>		(County)  (State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>						
ACTUAL SIGNATURE <i>Ludwig Benedict</i>		DATE SIGNED <b>6/13/57</b>						
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/18/57</b>		22b. DATE THEREOF <b>6/18/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Crownsville State Hosp.</b>		22d. LOCATION (City, town, or county) <b>Crownsville, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Meng</i>		ADDRESS <b>Crownsville, Md.</b>		24a. REC'D BY REGISTRAR <b>6/18/57</b>		24b. REGISTRAR'S SIGNATURE <i>J. M. Meng</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

REGISTRATION

DEATH CERTIFICATE

BUREAU Y.

JUN 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5874

## CERTIFICATE OF DEATH

05924

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel		c. LENGTH OF STAY IN lb RURAL and give nearest town)						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Davidsonville, Md.						
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MARY Louise SULLIVAN		4. DATE OF DEATH JUNE 25 1957						
First Middle Last		Month	Day	Year				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1900	9. AGE (in years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME John Butler Marshall		14. MOTHER'S MAIDEN NAME Daisy Beck Marshall		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Howard E. Sullivan, Davidsonville, Md.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 8 days				
DUE TO (c)		Gathered by <u>Vascular disease</u> hypertension						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 447X					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 6/17, 1957, to 6/25, 1957, that I last saw the deceased alive on 6/25, 1957, and that death occurred at 7:59 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Maurice F. Klavans, M.D.					ADDRESS (Street, city or town, state) 31 South 9th St, Baltimore, Md.			DATE SIGNED 6/25/57
PHYSICIAN'S NAME (Type) MAURICE F. KLAVANS, MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/57		22c. NAME OF CEMETERY OR CREMATORIAL Fort Belvoir		22d. LOCATION (City, town, or county) Prince George's Co.		
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co., Inc.		ADDRESS Washington, D.C. 1300 N St NW		24a. REG'D BY REGISTRAR JUN 27 1957			24b. REGISTRAR'S SIGNATURE W. J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

机架号: 200011140-0010-049 日期: 2012-09-27 09:48:39

BUREAU V.

-501 28 JUN

REFUGEE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05925

5875

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	c. LENGTH OF STAY IN lb <u>13 days.</u>	b. COUNTY <u>ANNE ARUNDEL</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA, RURAL</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>	d. STREET ADDRESS <u>Rt. 1, Long Point</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u>	Middle <u>Peter</u>	Last <u>SUSCAVAGE</u>	4. DATE OF DEATH Month <u>June</u> Day <u>1</u> , Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1913</u>
9. AGE (In years last birthday) <u>44 yrs.</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u>	12. IF UNDER 24 HRS. Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mc Drydock</u>	
10c. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor</u>		14. MOTHER'S MAIDEN NAME <u>SUSCAVAGE Era Kasulin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>187-03-6628</u>	
17. INFORMANT <u>MRS. Grace Suscavage, Same</u>		Address <u>1047 2nd Street, Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Peritonitis, generalized</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Perforation of stomach</u>		3 days	
(c) <u>Acute Gastric Inflammation of stomach</u>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>GASTRECTOMY 5/23/57, Expl. lap. 5/29/57</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>576X</u>		20b. DESCRIBE HOW INJURY OCCURRED! (Enter nature of injury in Part I or Part II if item 18.) <u>Exploratory laparotomy</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23-1957</u> to <u>6-1-1957</u> , that I last saw the deceased alive on <u>5-31-1957</u> , and that death occurred at <u>12:13 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D.		ADDRESS (Street, city or town, state) <u>98 Cathedral St, Baltimore, Md.</u> DATE SIGNED <u>June 1, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JUNE 4-1957</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEVADA STATE DEPARTMENT OF NEVADA - BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

BUREAU Y.

JUN 4 1957

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

15926

**5876 CERTIFICATE OF DEATH**

Reg. Dist. No. 21

**1. PLACE OF DEATH**

COUNTY	Anne Arundel	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Lynnopolis	LENGTH OF STAY (in this place)
TOWN		37 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel General Hos	

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE	Md	COUNTY	Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town)	Jewell	STREET ADDRESS	(If rural give location)
OR TOWN	XO		

**3. NAME OF  
DECEASED  
(Type or Print)**

(First) (Middle) (Last)

RECEIVED - BY MAIL - AIR MAIL - TELEGRAMS - CABLEGRAMS

U. S. GOVERNMENT  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
CERTIFICATE OF DEATH

SEARCHED	INDEXED
SERIALIZED	FILED
JUN 7 1957	
FBI - NEW YORK	

BUREAU Y.

JUN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5877

05927

Reg. Dist. No.

21

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>A.A.C.D.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>LIFE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Anne Arundel General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harry Raymond Taylor.</i>		First <i>Harry</i>	Middle <i>Raymond</i>
4. DATE OF DEATH <i>May 17, 1957</i>		Month <i>5</i>	Day <i>13</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 17, 1919</i>		9. AGE (in years last birthday) <i>44 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Raymond Taylor</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	
16. SOCIAL SECURITY NO. <i>W.W. II</i>		17. INFORMANT <i>Mrs THELMA TAYLOR 5208 Ritchie Hwy</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.3</i> <i>Sleek Disease</i>		Address <i>Scared</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		DUE TO (c) <i></i>	
DUE TO (b) <i></i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State) <i></i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		DATE SIGNED <i>6/13/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 17, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill</i>
22d. LOCATION (City, town, or county) <i>md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Gance 4001 Ritchie Hwy</i>		24a. RECEIVED BY REGISTRAR <i>JUN 20 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Tom Launchy</i>
		DATE	

DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3  
JUN 21 1957  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5931

## CERTIFICATE OF DEATH

05928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 4 mos. 12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		15562 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Good Hope Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Herbert</b>		First	Middle	Last	4. DATE OF DEATH <b>Thornton</b>	Month <b>6</b>	Day <b>19</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/20</b>	9. AGE (In years last birthday) <b>37 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Henry Thornton</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Jackson</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Asthma, Asthenia</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>7/16</b> , 19 <b>56</b> , to <b>6/19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/19</b> , 19 <b>57</b> , and that death occurred at <b>7:10 p.m.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>		DATE SIGNED <b>6/20/57</b>		
ACTUAL SIGNATURE <b>Lionel McHenry Mapp.</b>								
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-24-57</b>		22b. DATE THEREOF <b>6-24-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Barnes Co.</b>		ADDRESS <b>1432 - You N. N. C. 25 1957</b>		24a. REC'D BY REGISTRAR DATE <b>J. M. Joyce</b>		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HIGHWAYS-GASOLINE  
CERTIFICATE OF DELIVERY

BUREAU V. 2

JUN 25 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your information.

VS. A15ME(5)  
5M 9/55

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05929 <i>24</i>	Reg. Dist. No.	
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Anne Arundel</i> MARYLAND					<b>2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)</b> a. STATE <i>Maryland</i> <b>A.X.</b> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i> c. LENGTH OF STAY IN 1b <i>One hour</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>2013 Kernan Drive</i>					<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Severn River</i>												
<b>3. NAME OF DECEASED (Type or print)</b> <i>Dale Franklyn Turley</i>		First	Middle	Last	<b>4. DATE OF DEATH</b> <i>June 30th, 1957</i>		Month	Day	Year			
<b>5. SEX</b> <i>M.</i>		<b>6. COLOR OR RACE</b> <i>W.</i>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>	<b>8. DIVORCED</b> <input type="checkbox"/>	<b>9. DATE OF BIRTH</b> <i>3/8/40</i>		<b>10. AGE (in years to nearest birthday)</b> <i>17 yrs.</i>	<b>11. BIRTHPLACE (State or foreign country)</b> <i>St. Louis, Missouri.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>		
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <i>Student</i>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b>							
<b>13. FATHER'S NAME</b> <i>Harold E. Turley</i>					<b>14. MOTHER'S MAIDEN NAME</b> <i>Ruth Maybelle Webb</i>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)</b>					<b>16. SOCIAL SECURITY NO.</b> <i>219-26-2604</i>		<b>17. INFORMANT</b> <i>Mr. and Mrs. H.E. Turley, (parents).</i>		Address			
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <i>929.8</i> <b>Accidental Drowning</b>										INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> <i>DUE TO</i> <i>(c)</i>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <i>Drowning (Developed cramps)</i>							
<b>20c. TIME OF INJURY</b> <i>12.43 p. m.</i>		Month, Day, Year <i>6/30th</i>	<b>20d. INJURY OCCURRED</b> <i>While at work</i> <input type="checkbox"/> <i>Not while at work</i> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <i>Severn River</i>		<b>20f. (City or town)</b> <i>Sverna Park, A.A. Md.</i>		<b>(County)</b> <i></i>		<b>(State)</b> <i></i>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>												
<b>ACTUAL SIGNATURE</b> <i>Gustave H. Faubert, M.D.</i>												
<b>DATE SIGNED</b>												
<b>EXAMINER'S NAME (Type)</b> <i>Gustave H. Faubert, M.D.</i>												
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>JUNE 30TH 1957</b>												
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>22b. DATE THEREOF</b> <i>7-3-1957</i>		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <i>Lorraine Park</i>			<b>22d. LOCATION (City, town, or county)</b> <i>Woodlawn,</i> <b>Md.</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Howard Strong 3107 W. North Ave.</i>		<b>ADDRESS</b> <i></i>		<b>24a. REC'D BY REGISTRAR</b> <i>JUL 2 1957</i>			<b>24b. REGISTRAR'S SIGNATURE</b> <i>J. Nellis</i>					

BUREAU U. S.

JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5933 CERTIFICATE OF DEATH

05930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i>		c. LENGTH OF STAY IN 1b <i>x2 PASADENA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HAUREL DRIVE-PINE HAVEN</i>		d. STREET ADDRESS <i>HAUREL DRIVE Pine Haven</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Arthur G. Turlington</i>		First <i>G.</i>	Middle <i>Turlington</i>
4. DATE OF DEATH <i>JUNE 21 1957</i>		Last <i>JUNE</i>	Month <i>21</i>
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>JULY 14 1883</i>		9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HABORER RET</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CAN Co</i>	11. BIRTHPLACE (State or foreign country) <i>Georgia</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Thomas W. Turlington</i>		14. MOTHER'S MAIDEN NAME <i>Jannie Davis</i>	
15. WAS DECEDENT EVER IN U. S. ARMED FORCES? (Yes, no. If unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>	
17. INFORMANT <i>James I. Turlington</i>		Address <i>3833 Ferndale Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerotic Cardio Thrombo. Disease</i>		10 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Riviera Beach Md.</i>
20f. (City or town) <i>Riviera Beach Md.</i>		(County) <i>4122157</i> (State) <i>Md</i>	
21. I certify that I attended the deceased from <i>June 19, 1957</i> , to <i>June 21, 1957</i> , that I last saw the deceased alive on <i>June 19, 1957</i> , and that death occurred at <i>Riviera Beach Md.</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Riviera Beach Md.</i>	
ACTUAL SIGNATURE <i>J. Brady Smith</i>		DATE SIGNED <i>6/22/57</i>	
PHYSICIAN'S NAME (Type) <i>J. Brady Smith</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-25-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Weston Cem</i>
22d. LOCATION (City, town, or county) <i>Baltimore Md</i>		(State) <i>Md</i>	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>J. M. Walters</i>		22f. ADDRESS <i>1720 St. Paul St.</i>	22g. REC'D BY REGISTRAR <i>JUN 24 1957</i>
		22h. REGISTRAR'S SIGNATURE <i>L. J. Deallas</i>	

## MANHATTAN STATE GOVERNMENT OF NEW YORK - ALBANY

## CERTIFICATE OF DEATH

BUREAU V. A.  
RECEIVED  
JUN 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05931

5878

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN lb <i>10 days</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Minneapolis</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.C. General Hosp</i>		d. STREET ADDRESS <i>1 Carver St.</i>	
3. NAME OF DECEASED (Type or print) <i>John A. Turner</i>	First <i>John</i>	Middle <i>A.</i>	Last <i>Turner</i>
4. SEX <i>Male</i>	5. COLOR OR RACE <i>Col.</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>3-11-1921</i>
8. AGE (in years ( <del>last</del> birthday) yrs.) <i>38</i>	9. IF UNDER 1 YEAR Months <i>8</i>	10. IF UNDER 24 HRS. Days <i>6</i>	11. Year <i>1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Poynor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Yacht Club</i>	11. BIRTHPLACE (State or foreign country) <i>Bristol, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Oliver Turner</i>	14. MOTHER'S MAIDEN NAME <i>Florence Owens</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>230-16855</i>	17. INFORMANT <i>Margie Brown, Anna, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)			
<i>Cardiac Failure</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1st.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/15</i> , 19 <i>57</i> , to <i>6/2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/7</i> , 19 <i>57</i> , and that death occurred at <i>32 Calvert St.</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Theodore H. Johnson, Jr.</i>	PHYSICIAN'S NAME (Type) <i>Dr. Theodore H. Johnson, Jr.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-9-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Moses</i>	22d. LOCATION (City, town, or county) <i>Dreveny, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Anna, Md.</i>	ADDRESS	24a. REGISTRATION DATE <i>JUN 13 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Tom J. French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, copy the funeral director, page 3, and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

REGISTRATION

EXPIRATION DATE

BUREAU V. S.

JUN 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05932

5879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1  
Items 18-21 Film 217 75 57 are

1. PLACE OF DEATH a. COUNTY  Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  10 Annapolis						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Anne Arundel General Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)  First ERNEST		Middle WALSH	Last	4. DATE OF DEATH Month June Day 19 Year 1957						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8 <sup>th</sup> 1925	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROUTEMAN		10b. KIND OF BUSINESS OR INDUSTRY CHALING BREWERY		11. BIRTHPLACE (State or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William		14. MOTHER'S MAIDEN NAME Alma		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16. SOCIAL SECURITY NO.				
17. INFORMANT GERALDINE WALSH		Address R.I. Box 270 F EDGEWATER, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 971.8 DUR TOXIC		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute alcoholism (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Phosphorus poisoning		20c. TIME OF INJURY Month, Day, Year Hour p. m. 6/19/57 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Unknown	20f. (City or town) Annapolis	(County) A.A.	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE  Paul F. Guerin		DATE SIGNED 6/19/57								
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL/CREMATION REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6-24-57		22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) ARLINGTON VIRGINIA		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulon		ADDRESS 3831 - 2nd Avenue DC		24a. REC'D BY REGISTRAR JUN 26 1957		24b. REGISTRAR'S SIGNATURE John J. French				

**RECEIVED**

JUN 26 1957

**BUREAU K-8**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5934

## CERTIFICATE OF DEATH

05933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>7 yrs. 6 mos. 3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3 Yrs 1 - 4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>404 N. Durham Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Gertrude</b>		First	Middle	Lost	4. DATE OF DEATH <b>6 19 1957</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/90</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Preacher</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Not given</b>				14. MOTHER'S MAIDEN NAME <b>Not given</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>State Hospital Crownsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>522X Hypostatic Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Senility and Malnutrition</b> (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Cardiovascular Disease</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>6/12 1957</b> to <b>6/19 1957</b> , that I last saw the deceased alive on <b>6/19 1957</b> , and that death occurred at <b>2:45 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>6/19/57</b>								
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		M.D.						
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Embal.</b>		22b. DATE THEREOF <b>8-20-57 1:00 p.m. Hospital</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese # 108 W. 7th St. Annapolis</b>		ADDRESS <b>108 W. 7th St. Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>6/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. M. Hayes</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be rejoined by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

REGELY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5880

## CERTIFICATE OF DEATH

05934  
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 Hill Street</b>		d. STREET ADDRESS <b>3 Hill Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>L</b>	WELLS	4. DATE OF DEATH <b>JUNE 18</b>	Month <b>JUNE</b>	Day <b>18</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1882</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Levy</b>				14. MOTHER'S MAIDEN NAME <b>Mary Barbars (unknown) MORAVETZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Daniel W. Wells- Husband- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>ARTERIOSCHROSIS, GENERALIZED</b> (c) <b>UNKNOWN</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>450.0</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ADDRESS (Street, city or town, state)</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 18, 1957</b> to <b>June 1957</b> , that I last saw the deceased alive on <b>18 June 1957</b> , and that death occurred at <b>5:12 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Edward S. Beck</b> M.D. DATE SIGNED <b>6-19-57</b>							
ACTUAL SIGNATURE <b>Edward S. Beck</b>							
PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b> 41 Southgate Ave., Annapolis, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b> (State) <b>VS A15 (4) 15M 9/55</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>John J. French</b>	

8  
after death: Page A

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

RECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached from the body of the certificate and given to the funeral director.

TO HOSPITAL  
may be  
TO FUNERAL

VS A15  
15M 9%

BUREAU V.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07105

(7053)

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A A General</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodland Beach</i>	
d. STREET ADDRESS <i>RT 3 Box 630</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MATTHEW JOHN WILMER</i>		First <i>MATTHEW</i>	Middle <i>JOHN</i>
4. DATE OF DEATH <i>June 30 1957</i>		Lost <i>June</i>	Month <i>Month</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7/18/1902</i>		9. AGE (In years last birthday) <i>54 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WELL DRILLER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Phila Pa.</i>	10c. BIRTHPLACE (State or foreign country) <i>Phila Pa.</i>
11. CITIZEN OF WHAT COUNTRY? <i>RT 3 Box 630</i>		12. FATHER'S NAME <i>George W. WILMER</i>	
13. MOTHER'S MAIDEN NAME <i>MARGARET CASSIDY Edgewater Md.</i>		14. MOTHER'S MAIDEN NAME <i>ANNA C. WILMER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WWI</i>	
17. INFORMANT <i>ANNA C. WILMER</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS &amp; MYOCARDIAL INFARCTION</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>HYPERTENSIVE CARDIO-VASCULAR DISEASE</i> (b) DUE TO <i>2 YRS.</i> (c)	
19. MEDICAL CERTIFICATION <i>490 Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 208 BAR PNEUMONIT, RIGHT LUNG</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 DAYS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>SEPT. 1952</i> to <i>JUNE 1957</i> , that I last saw the deceased alive on <i>2 JUNE 1957</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Beck</i> PHYSICIAN'S NAME (Type) <i></i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/1/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>US National</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bruce Hardisty Galiville Md</i>		24. READ BY REGISTRAR DATE <i>JUL 5 1957</i>	
ADDRESS <i></i>		25. REGISTRAR'S SIGNATURE DATE <i>V. French</i>	

WISCONSIN STATE GOVERNMENT OF GREENSBURG - BIRTMORE 78

CERTIFICATE OF DEATH

DEATH CERTIFICATE

REGISTRATION

RECEIVED

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BUREAU V. S.

JUL 8 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05935

5935

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>32 yrs. 2 mos. 20 days</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>						
3. NAME OF DECEASED (Type or print)		First <b>Edam</b>	Middle <b>Wilson</b>					
4. DATE OF DEATH	Month <b>6</b>	Day <b>28</b>	Year <b>1957</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1880</b>					
9. AGE (In years lost birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —					
13. FATHER'S NAME <b>Not given</b>	14. MOTHER'S MAIDEN NAME <b>Not given</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service) <b>Unk.</b>			16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT <b>Hospital Records</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) General Arteriosclerosis	19. MEDICAL CERTIFICATION TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21. I certify that I attended the deceased from <b>12/3 1957</b> to <b>6/28 1957</b> , that I last saw the deceased alive on <b>6/21 1957</b> , and that death occurred at <b>6:30 a.m.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Cyril G. Hardy</i> PHYSICIAN'S NAME (Type) <b>Cyril G. Hardy, M. D.</b>			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. g. p. m.	Month <b>19</b>	Day <b>19</b>	Year <b>57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Crownsville State Hospital</b>	20f. (City or town) <b>Crownsville</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. BURIAL, CREMATION, REMOVAL (Specify) <b>7/3/57</b>	22b. DATE THEREOF <b>7/3/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Crownsville State Hospital</b>	22d. LOCATION (City, town, or county) <b>Crownsville</b>	(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barber</i>	ADDRESS <b>William Barber</b>	24b. REC'D BY REGISTRAR DATE <b>7-3-57</b>	24b. REGISTRAR'S SIGNATURE <b>L. M. Joyce</b>					

WISCONSIN STATE GOVERNMENT OF MURKIN-GARLICKER 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
WILLIAM HENRY GARDNER						
65 years		Male	July 8, 1957	10:00 AM	Cardiac arrest	18-100000000000000000
Died at home						
Cause of death: Cardiac arrest						
Autopsy performed by Dr. John Doe						
Burial or cremation: Burial						
Date of death certificate: July 8, 1957						
Signature of physician: Dr. John Doe						
Signature of coroner: Dr. John Doe						
Signature of state health officer: Dr. John Doe						

BUREAU U.S.

JUL 8 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5936

05936

Item 1 Film G218 7-18-57 et

Reg. Dist. No. 21

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>A.H. Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Arco</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					
3. NAME OF DECEASED (Type or print) <i>Elmer.</i>		First <i>Elmer.</i>	Middle <i>M.</i>		
4. DATE OF DEATH <i>6 30 1957</i>		Last <i>Wines</i>	Month <i>6</i> Day <i>30</i> Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Jan 12, 1916</i>		
		DIVORCED <input type="checkbox"/>	9. AGE (In years and birthday) <i>41 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Warrenton, Va.</i>		
13. FATHER'S NAME <i>Elmer M. Wines</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Pearl M. Wines</i> Address <i>Edgewater, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>Under</i>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E. L. Lawrence</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6/30/57</i>		
EXAMINER'S NAME (Type) <i>E. L. Lawrence</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 3, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryant Jr.</i>	ADDRESS <i>317 Penna. Ave. S.E.</i>		24a. REC'D BY REGISTRAR <i>7/3/57</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. C. French</i>	

BUREAU V. 2

JUL 3 1957

RECEIVED